

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

12731 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12707
32

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville 8.</i>		c. LENGTH OF STAY IN 1b <i>4 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7628 Carla Rd</i>		d. STREET ADDRESS <i>7628 Carla Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SYDNEY BERNARD ALBERT</i>		4. DATE OF DEATH <i>Dec 6 1957</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 1, 1914</i>	
9. AGE (In years last birthday) <i>43 yrs.</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Jewelry</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Isidore Albert</i>		14. MOTHER'S MAIDEN NAME <i>Ida Rucka</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>yes World War 2</i>		16. SOCIAL SECURITY NO. <i>216-05-0817</i>	
17. INFORMANT <i>Henry Goldsmith</i>		Address <i>3404 Labarinto Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Occlusion</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>none 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) (County) (State) <i>none</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>12-6-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-8-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Herring Run</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>		ADDRESS <i>2100 Eutaw Place</i>	
24a. REC'D BY REGISTRAR <i>DEC 10 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Donnyhewell</i>	

RECEIVED

DEC 10 1957

BUREAU V. S.

12732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u> 6				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2. Raspeburg</u> 6			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 304 Gumspring Rd.</u>				d. STREET ADDRESS <u>Box 304 Gumspring Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Carol</u> Last <u>Amos</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-57</u>	9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Al Fred Amos</u>				14. MOTHER'S MAIDEN NAME <u>Ella May Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father</u> Address <u>Box 304 GUMSPRING RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>undet</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John C. Hyle</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. COUNTY, MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B. Locke, Jr.</u>				ADDRESS <u>1304 N. Central Ave</u>		24a. REC'D BY REGISTRAR DATE <u>12/17/57</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Thompson</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ALABAMA STATE DEPARTMENT OF HEALTH - ALBANY 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH	
6. PLACE OF DEATH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER	
11. SIGNATURE OF WITNESS		12. SIGNATURE OF WITNESS		13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS	
26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS	
36. SIGNATURE OF WITNESS		37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS		49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS	
51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS	
56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS	
66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS	
71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS		73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS		85. SIGNATURE OF WITNESS	
86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS	
96. SIGNATURE OF WITNESS		97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

RECEIVED
DEC 13 1957
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 637 Coleraine Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last ANDREWS		4. DATE OF DEATH Month December Day 26 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1919
9. AGE (in years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto Body Shop	
11. BIRTHPLACE (State or foreign country) McKeesport, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME - Andres		14. MOTHER'S MAIDEN NAME - Fulmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Catherine L. Andrews, 637 Coleraine Rd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		DATE SIGNED 12/26/57	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 30. 57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	22d. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd. Balto. Md
23. FUNERAL DIRECTOR'S SIGNATURE THOMAS J. KENNY, INC. 1600 HOLLINS ST. BALTO. MD.		24a. REC'D BY REGISTRAR DEC 27 '57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 30 1957

BUREAU V. B.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

12734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Baltimore City Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 51 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 512 Cording Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD --- APPEL				4. DATE OF DEATH Month Day Year December 18 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1897		9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Roofing Business		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard Appel				14. MOTHER'S MAIDEN NAME Ida Berndt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-10-1351		17. INFORMANT Address Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 522x DUE TO UNKNOWN CAUSE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
1. Gangrene, right foot. 2. Multiple sclerosis. Operation - Hemorrhoidectomy, 10 years ago.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28, 1957, to December 18, 1957 and that death occurred at 8:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 12/18/57							
ACTUAL SIGNATURE Joseph M. Miller		M.D. VAH, FORT HOWARD, MARYLAND					
PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief, Surgical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Govans Presbyterian Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran, 3000 E. Baltimore St., Baltimore, Md.				24a. REC'D BY REGISTRAR DEC 19 1957		24b. REGISTRAR'S SIGNATURE D.L. Farber	

87

RECEIVED

12735

CERTIFICATE OF DEATH

12711

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CATON RIDGE NURSING HOME</u>		d. STREET ADDRESS <u>943 WEBB CT</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>ARMAN</u> Middle <u>ARMAN</u> Last		4. DATE OF DEATH <u>DEC.</u> Month <u>16th</u> Day <u>MON.</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1882</u> 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
13. FATHER'S NAME <u>JACOB</u>		14. MOTHER'S MAIDEN NAME <u>FRANCES CHMIELEWSKI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DOROTHY EIN WILIT 49-ILP MANOR</u>		Address <u>RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>14y pulmonary & Arterio sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/10/57</u> , 1957, to <u>12/16/57</u> , that I last saw the deceased alive on <u>12/13/57</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cliff Ratliff, Jr.</u> M.D.		DATE SIGNED <u>4605 Edmondson Ave 12/16/57</u>	
PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>		<u>4605 EDMONDSON AVE.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE <u>DEC 19 57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 10

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1912</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1935</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Dec 10 1957</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. DATE OF REGISTRATION <i>Dec 11 1957</i></p>	

BUREAU V. B.

DEC 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12736

CERTIFICATE OF DEATH

Reg. Di

12712

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. LENGTH OF STAY IN 1b 54 BALTIMORE rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7224 Eastern Ave.				d. STREET ADDRESS 7224 Eastern Blvd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle E Last ATKINSON				4. DATE OF DEATH Month DEC Day 4 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 4, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) track foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cecil Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisha A. Atkinson				14. MOTHER'S MAIDEN NAME Isabel Jay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-69-7438		17. INFORMANT Raymond S. Atkinson		Address 7224 Eastern Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident (2nd) DUE TO (c) Advanced, generalized Atherosclerosis & HCVD						INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 wks undet	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition and electrolyte imbalance Secondary to (a) above						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Mar. 19 56 , to Dec. 4 19 57 , that I last saw the deceased alive on Dec 3 19 57 , and that death occurred at 9:15p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7527 Belair Rd Balto 6 Md DATE SIGNED Dec 6, 57							
ACTUAL SIGNATURE John C. Hyle		M.D. JOHN C. HYLE MD					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Lubbock Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DEC 9 1957	24b. REGISTRAR'S SIGNATURE Edith H. Hyle		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

12737 CERTIFICATE OF DEATH

12713 33
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS Mills, Maryland		c. LENGTH OF STAY IN 1b 16 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROSEWOOD STATE TRAINING School		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 16, MARYLAND d. STREET ADDRESS 2104 ELSINOR AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN LYNN BANNISTER		4. DATE OF DEATH Month Day Year 12 18 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	9. AGE (In years lost birthday) 22 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GILBERT BANNISTER		14. MOTHER'S MAIDEN NAME LUCILE SCHULER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT ROSEWOOD RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO-PNEUMONIA (ACUTE BRONCHITIS) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DECUBITUS ULCER OF THE SACRUM DUE TO (c) SPASTIC QUADRIPLÉGIA			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Microcephaly			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/18 , 19 57 , to 12/18 , 19 57 , that I last saw the deceased alive on 12/18 , 19 57 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest J. Decuo		ADDRESS (Street, city or town, state) Rosewood Lane Owings Mills, Md. DATE SIGNED 12/18/57	
PHYSICIAN'S NAME (Type) ERNEST J. DECUO		ROSEWOOD STATE TRAINING School	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec. 24, 1957	22b. DATE THEREOF Dec. 24, 1957	22c. NAME OF CEMETERY OR CREMATORY Worthington M. Harford Co. Md.	22d. LOCATION (City, town, or county) (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey		24a. REG'D BY REGISTRAR Dec. 24, 1957 24b. REGISTRAR'S SIGNATURE C. J. Kirdy Mary Elmer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint handwriting.

BUREAU V. 2

DEC 27 1957

RECEIVED

EXPERT 1 DEC 27
J. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12738 CERTIFICATE OF DEATH

12714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oaklee Village		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Oaklee Village	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 128 Oaklee Village		e. STREET ADDRESS 128 Oaklee Village	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Barber Last		4. DATE OF DEATH Month Dec. Day 15 Year 57	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ---Harger		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218 12 4950	
17. INFORMANT Mrs. Helen Cullen, 128 Oaklee Village		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) THROMBOPHLEBITIS LEFT LEG		INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 10, 1956 , to DEC 15, 1957 , that I last saw the deceased alive on DEC 17, 1957 , and that death occurred at 5:45 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Kennard Yaffe		ADDRESS (Street, city or town, state) 3101 W BALTIMORE ST.	
PHYSICIAN'S NAME (Type) KENNARD YAFFE		DATE SIGNED 12/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Pl.		22d. LOCATION (City, town, or county) (State) Baltimore MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson		24a. REC'D BY REGISTRAR W. L. Smith	
ADDRESS 4101 Edmondson		DATE DEC 18 57	

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

12739

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12715
Reg. Dist. No.

ITEMS 1, 2, 8 & 9 Film G223 12/27/57 GLE

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Timonium	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 174 Cinder Road		d. STREET ADDRESS 174 174 Cinder Road	
3. NAME OF DECEASED (Type or print) MARIAN ELLEN BEARDSLEY		4. DATE OF DEATH Month December Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 October 27, 1957
9. AGE (In years last birthday) yrs. 7 Months 19 Days 19		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Warren H. Beardsley		14. MOTHER'S MAIDEN NAME Kathryn Walsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Warren H. Beardsley, Timonium, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 475x Upper Respiratory Infection DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 475x DUE TO cause lost (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24 Hours		INTERVAL BETWEEN ONSET AND DEATH 24 Hours	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) C. Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/9/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 12, 1957	22c. NAME OF CEMETERY OR CREMATORY May's Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Timonium, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sono		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR DATE DEC 13 '57		24b. REGISTRAR'S SIGNATURE W. J. Smith	

2044223XV3

MARY AND STATE DEPARTMENT OF HEALTH BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

BUREAU V. S.

DEC 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12740

CERTIFICATE OF DEATH

12716/5

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River				c. LENGTH OF STAY IN b. 4 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Ivy Hall, 190 Harrison Ave.				d. STREET ADDRESS Baltimore 1740 Fleet St.,			
3. NAME OF DECEASED (Type or print) Anna First Behr Middle — Last Behr				4. DATE OF DEATH Dec Month 31 Day 1957 Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May. 9. 1873		9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ferdinand Schneider				14. MOTHER'S MAIDEN NAME Anna Woelfel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Ferdinand E. Behr. 2600 Jefferson St. Balto. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardio-Vascular disease DUE TO disease (c)						1 day 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 1 , 19 57 , to Dec 31 , 19 57 , that I last saw the deceased alive on Dec 31 , 19 57 , and that death occurred at 6 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Banngardner M.D.				ADDRESS (Street, city or town, state) Baltimore Md		DATE SIGNED 12/31/57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3. 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS, INC. Baltimore Md. ADDRESS				24a. REC'D BY REGISTRAR JAN 6 1958		24b. REGISTRAR'S SIGNATURE Edith Hurley	

BUREAU V.

JAN 6 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1274 CERTIFICATE OF DEATH

12717 40

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingsville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kingsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bradshaw Rd.</u>				STREET ADDRESS (If rural give location) <u>Bradshaw Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bertha</u>		(Middle) <u>S.</u>		(Last) <u>Bell</u>		(Month) <u>Dec.</u> (Day) <u>5</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 22, 1878</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jarrett Standiford</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. William W. Bell Kingsville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CVA left side paralysis</u>				<u>3 mo</u>			
19a. DATE OF OPERATION <u>4-2-57</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 29, 1957</u> , to <u>Dec. 5, 1957</u> , that I last saw the deceased alive on <u>Dec. 5, 1957</u> , and that death occurred at <u>6:20</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William W. Tyson</u>				DATE SIGNED <u>12-5-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 8, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Salem Methodist</u>		LOCATION (City, town, or county) (State) <u>Kingsville Md. 12-5-57</u>	
24. RECEIVED BY REGISTRAR <u>DEC 9 1957</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter H. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. ...</u>		ADDRESS <u>Franklinville Rd. Balto. Co. 7401 Belair Rd.</u>	

CERTIFICATE OF DEATH

Case No. 15-17

IN THE CASE OF

NAME OF DECEASED
 SEX
 AGE
 OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

DEC 9 1957

RECEIVED

INFORMATION

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT, FOR A FEE OF FIVE CENTS. IT IS TO BE DESTROYED AFTER THE FIFTY-YEAR PERIOD HAS EXPIRED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12742 CERTIFICATE OF DEATH

12742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>55 Towson</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>613 St. Francis Road</i>		d. STREET ADDRESS <i>613 St. Francis Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mr. Edward Joseph Bennett</i>		4. DATE OF DEATH <i>December 25th 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 24, 1900</i>
9. AGE (In years last birthday) <i>57</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Bennett</i>		14. MOTHER'S MAIDEN NAME <i>Mary Anna Schmidt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Laura Rita Bennett, 613 St. Francis</i>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 minutes</i>
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>2 1/2 hrs.</i> 19 <i>57</i> , to <i>1 30 AM</i> 19 <i>57</i> , that I last saw the deceased alive on <i>12/25</i> 19 <i>57</i> , and that death occurred at <i>1 30 A</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1515 Martin Blvd</i>	
ACTUAL SIGNATURE <i>Joseph J. Cameron</i>		DATE SIGNED <i>12/26/57</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH J. CAMERON</i>		M.D.	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/28/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>DEC 30 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Nabel Gray</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12719 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>2 YRS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8107 ROSEBANK AVE.</u>	
d. STREET ADDRESS <u>18107 ROSEBANK AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE HEIM BENNETT</u>		4. DATE OF DEATH Month Day Year <u>12-24-1957</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. BENNETT</u>		14. MOTHER'S MAIDEN NAME <u>ANNA BRAUN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>192-28-2187</u>	
17. INFORMANT Address <u>MRS. MARGON STABLEY - DUNDALK, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION -</u> <u>420.1</u> DUE TO <u>A-S-C-V-Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ALTONA, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Bradley, Dundalk, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. K. H. H. H.</u>	

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEC 27 1957

BUREAU

RECEIVED

12743 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS RED # 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harrison Middle Bishop Last Sr.				4. DATE OF DEATH Month 12 Day 25 Year 1957			
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-02	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 12 Days 25 Hours 19 Min.	IF UNDER 24 HRS. Months 12 Days 25 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY North Carolina		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME James L. Bishop				14. MOTHER'S MAIDEN NAME Maggie R. Bishop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-24-542		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Histoplasmosis 134.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 months DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 0 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-22, 1957 , to 12-25, 1957 , that I last saw the deceased alive on 12-25, 1957 , and that death occurred at 4:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland							
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 29, 1957		22c. NAME OF CEMETERY OR CREMATORY Bell Air Memorial Park		22d. LOCATION (City, town, or county) (State) Harford Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey				ADDRESS Wilmington Md		24a. REC'D BY REGISTRAR DATE Dec 27, 1957	
						24b. REGISTRAR'S SIGNATURE Barthelme	

12744 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Middle Last EARLE W. BLACKBURN		4. DATE OF DEATH Month Day Year December 14 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/12/94
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		9b. KIND OF BUSINESS OR INDUSTRY Real Estate	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Henry Blackburn		14. MOTHER'S MAIDEN NAME Cecilia Spicer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-03-5873	
17. INFORMANT Clin. Recs. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY ABSCESS 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 27, 19 57 , to December 14, 19 57 , that I last saw the deceased alive on December 12, 19 57 , and that death occurred at 5:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Fort Howard, Maryland DATE SIGNED 12/14/57			
ACTUAL SIGNATURE Donald D. Mark M.D.		PHYSICIAN'S NAME (Type) DONALD D. MARK, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/57	
22c. NAME OF CEMETERY OR CREMATORY Hiss Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR DEC 17 1957	
24b. REGISTRAR'S SIGNATURE James L. Farley			

LEONARD J. RUCK FUNERAL HOME, 5305 HARFORD RD., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Form with multiple sections for death certificate data, including fields for name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. R.

DEC 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12722

, 12745 CERTIFICATE OF DEATH

Reg. Dist. No. 33

J. PLACE OF DEATH o. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY in 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 Berrymans Lane			d. STREET ADDRESS Berrymans Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Nora Middle Agnes Last Bollinger			4. DATE OF DEATH Month Dec. Day 5 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1907		9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Govt. Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Sylvester Bollinger			14. MOTHER'S MAIDEN NAME Margaret Flynn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Michael J. Bollinger, Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH at least 40 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 1957 , to Dec 5, 1957 , that I last saw the deceased alive on Nov 1957 , and that death occurred at 7 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Louis Dalmar		M.D. 413 Reisterstown Rd		DATE SIGNED Dec 6/57	
PHYSICIAN'S NAME (Type) Louis Dalmar		Pikesville 8, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.	
22d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.			24a. REC'D BY REGISTRAR DATE 12-6-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. PLACE OF BIRTH [REDACTED]</p>	
<p>10. OCCUPATION [REDACTED]</p>		<p>11. EDUCATION [REDACTED]</p>		<p>12. RELIGION [REDACTED]</p>	
<p>13. MARITAL STATUS [REDACTED]</p>		<p>14. DATE OF MARRIAGE [REDACTED]</p>		<p>15. NAME OF SPOUSE [REDACTED]</p>	
<p>16. NAME OF NEXT OF KIN [REDACTED]</p>		<p>17. ADDRESS OF NEXT OF KIN [REDACTED]</p>		<p>18. SIGNATURE OF NEXT OF KIN [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED [REDACTED]</p>		<p>20. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>21. SIGNATURE OF CORONER [REDACTED]</p>	
<p>22. SIGNATURE OF JUDGE [REDACTED]</p>		<p>23. SIGNATURE OF CLERK [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	

BUREAU V. 3

DEC 9 1957

RECEIVED

12746 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN b. 43 days		d. STREET ADDRESS 2745 N. Calvert St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRA Middle W. Last BOZMAN		4. DATE OF DEATH Month December Day 20 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1895
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Accntnt		10b. KIND OF BUSINESS OR INDUSTRY Rug Co.	
11. BIRTHPLACE (State or foreign country) Cape Charles, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Bozman		14. MOTHER'S MAIDEN NAME Sara Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 215-07-7256	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOMEGALY WITH HYPERTROPHY AND DILATATION of 443X RIGHT AND LEFT VENTRICLES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to: HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIO- VASCULAR DISEASE (c) INTERVAL BETWEEN ONSET AND DEATH 14 YEARS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from November 7, 1957 , to December 20, 1957 , and that death occurred at 7:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH FT. HOWARD, MARYLAND DATE SIGNED 12/20/57			
ACTUAL SIGNATURE Chien Wei Lan		M.D. VAH FT. HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-23-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner North & Pa. Ave Balto. Md		24a. REC'D BY REGISTRAR DEC 24 1957 24b. REGISTRAR'S SIGNATURE Lawson L. Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 24 1957

RECEIVED

12747 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4			
f. STREET ADDRESS 3621 Forrest Park Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DONALD Middle F. Last BROWN				4. DATE OF DEATH Month December Day 28 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/33	
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oilier-Checker		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nolan S. Brown		14. MOTHER'S MAIDEN NAME Anna Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes PL-28	
16. SOCIAL SECURITY NO. 216-30-5855		17. INFORMANT Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEOPLASM, METASTATIC 178x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EMBRYONAL CARCINOMA LEFT TESTICLE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 16 MONTHS 18 MONTHS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from December 6, 1957 , to December 28, 1957 , and that death occurred at 12:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Fort Howard, Md. 12/28/57							
ACTUAL SIGNATURE W. C. Dudley				M.D. W. C. DUDLEY, M.D.			
PHYSICIAN'S NAME (Type) W. C. DUDLEY, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, Inc.				24a. REC'D BY REGISTRAR DATE 12/30/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 8

DEC 31 1957

RECEIVED

12748

CERTIFICATE OF DEATH

1272533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chromie Road</u>		d. STREET ADDRESS <u>Chromie Road</u>	
3. NAME OF DECEASED (Type or print) First <u>HESTER</u> Middle <u>V.</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1879</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Meyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Bessie A. Nelson Chromie Rd Reisterstown</u>	
17. INFORMANT <u>Bessie A. Nelson Chromie Rd Reisterstown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 1956</u> , to <u>December 25, 1957</u> , that I last saw the deceased alive on <u>December 24, 1957</u> , and that death occurred on <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>Dec 25, 1957</u>	
PHYSICIAN'S NAME (Type) <u>CLARENCE E. McWILLIAMS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-28-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mary E. Long</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

BUREAU V. 3

DEC 30 1957

RECEIVED

BUN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12749 CERTIFICATE OF DEATH

127264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 18 months				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 23 3V01-4											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 54 S. FULTON AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First RAYMOND Middle BROWNING Last BROWNING				4. DATE OF DEATH Month 12 Day 24 Year 1957															
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-10-04		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER CHAUFFEUR, CITY OF BALTO.				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND				11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE BROWNING				14. MOTHER'S MAIDEN NAME ELIZABETH MANGRUM				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-03-8884				17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH TWO YEARS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from 7-6-1955 to 12-24-1955 , that I last saw the deceased alive on 12-24-1955 , and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 12-24-55 ACTUAL SIGNATURE William Newcomer M.D. Superintendent PHYSICIAN'S NAME (Type) William Newcomer, M.D.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-27-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.				22d. LOCATION (City, town, or county) (State) A. A. Co., Md.									
23. FUNERAL DIRECTOR'S SIGNATURE WITZKE FUNERAL DIR. EDMONDSON						ADDRESS 4101 AVE		24a. REC'D BY REGISTRAR DATE 12/27/57		24b. REGISTRAR'S SIGNATURE Dorothy Newell									

1957 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

File No. 18

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. OCCUPATION [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MANNER OF DEATH [REDACTED]</p>		<p>10. MEDICAL HISTORY [REDACTED]</p>	
<p>11. SOCIAL HISTORY [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>15. SIGNATURE OF CORONER [REDACTED]</p>		<p>16. SIGNATURE OF JURY [REDACTED]</p>	
<p>17. SIGNATURE OF JURY [REDACTED]</p>		<p>18. SIGNATURE OF JURY [REDACTED]</p>	
<p>19. SIGNATURE OF JURY [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>	
<p>21. SIGNATURE OF JURY [REDACTED]</p>		<p>22. SIGNATURE OF JURY [REDACTED]</p>	
<p>23. SIGNATURE OF JURY [REDACTED]</p>		<p>24. SIGNATURE OF JURY [REDACTED]</p>	
<p>25. SIGNATURE OF JURY [REDACTED]</p>		<p>26. SIGNATURE OF JURY [REDACTED]</p>	
<p>27. SIGNATURE OF JURY [REDACTED]</p>		<p>28. SIGNATURE OF JURY [REDACTED]</p>	
<p>29. SIGNATURE OF JURY [REDACTED]</p>		<p>30. SIGNATURE OF JURY [REDACTED]</p>	
<p>31. SIGNATURE OF JURY [REDACTED]</p>		<p>32. SIGNATURE OF JURY [REDACTED]</p>	
<p>33. SIGNATURE OF JURY [REDACTED]</p>		<p>34. SIGNATURE OF JURY [REDACTED]</p>	
<p>35. SIGNATURE OF JURY [REDACTED]</p>		<p>36. SIGNATURE OF JURY [REDACTED]</p>	
<p>37. SIGNATURE OF JURY [REDACTED]</p>		<p>38. SIGNATURE OF JURY [REDACTED]</p>	
<p>39. SIGNATURE OF JURY [REDACTED]</p>		<p>40. SIGNATURE OF JURY [REDACTED]</p>	
<p>41. SIGNATURE OF JURY [REDACTED]</p>		<p>42. SIGNATURE OF JURY [REDACTED]</p>	
<p>43. SIGNATURE OF JURY [REDACTED]</p>		<p>44. SIGNATURE OF JURY [REDACTED]</p>	
<p>45. SIGNATURE OF JURY [REDACTED]</p>		<p>46. SIGNATURE OF JURY [REDACTED]</p>	
<p>47. SIGNATURE OF JURY [REDACTED]</p>		<p>48. SIGNATURE OF JURY [REDACTED]</p>	
<p>49. SIGNATURE OF JURY [REDACTED]</p>		<p>50. SIGNATURE OF JURY [REDACTED]</p>	
<p>51. SIGNATURE OF JURY [REDACTED]</p>		<p>52. SIGNATURE OF JURY [REDACTED]</p>	
<p>53. SIGNATURE OF JURY [REDACTED]</p>		<p>54. SIGNATURE OF JURY [REDACTED]</p>	
<p>55. SIGNATURE OF JURY [REDACTED]</p>		<p>56. SIGNATURE OF JURY [REDACTED]</p>	
<p>57. SIGNATURE OF JURY [REDACTED]</p>		<p>58. SIGNATURE OF JURY [REDACTED]</p>	
<p>59. SIGNATURE OF JURY [REDACTED]</p>		<p>60. SIGNATURE OF JURY [REDACTED]</p>	
<p>61. SIGNATURE OF JURY [REDACTED]</p>		<p>62. SIGNATURE OF JURY [REDACTED]</p>	
<p>63. SIGNATURE OF JURY [REDACTED]</p>		<p>64. SIGNATURE OF JURY [REDACTED]</p>	
<p>65. SIGNATURE OF JURY [REDACTED]</p>		<p>66. SIGNATURE OF JURY [REDACTED]</p>	
<p>67. SIGNATURE OF JURY [REDACTED]</p>		<p>68. SIGNATURE OF JURY [REDACTED]</p>	
<p>69. SIGNATURE OF JURY [REDACTED]</p>		<p>70. SIGNATURE OF JURY [REDACTED]</p>	
<p>71. SIGNATURE OF JURY [REDACTED]</p>		<p>72. SIGNATURE OF JURY [REDACTED]</p>	
<p>73. SIGNATURE OF JURY [REDACTED]</p>		<p>74. SIGNATURE OF JURY [REDACTED]</p>	
<p>75. SIGNATURE OF JURY [REDACTED]</p>		<p>76. SIGNATURE OF JURY [REDACTED]</p>	
<p>77. SIGNATURE OF JURY [REDACTED]</p>		<p>78. SIGNATURE OF JURY [REDACTED]</p>	
<p>79. SIGNATURE OF JURY [REDACTED]</p>		<p>80. SIGNATURE OF JURY [REDACTED]</p>	
<p>81. SIGNATURE OF JURY [REDACTED]</p>		<p>82. SIGNATURE OF JURY [REDACTED]</p>	
<p>83. SIGNATURE OF JURY [REDACTED]</p>		<p>84. SIGNATURE OF JURY [REDACTED]</p>	
<p>85. SIGNATURE OF JURY [REDACTED]</p>		<p>86. SIGNATURE OF JURY [REDACTED]</p>	
<p>87. SIGNATURE OF JURY [REDACTED]</p>		<p>88. SIGNATURE OF JURY [REDACTED]</p>	
<p>89. SIGNATURE OF JURY [REDACTED]</p>		<p>90. SIGNATURE OF JURY [REDACTED]</p>	
<p>91. SIGNATURE OF JURY [REDACTED]</p>		<p>92. SIGNATURE OF JURY [REDACTED]</p>	
<p>93. SIGNATURE OF JURY [REDACTED]</p>		<p>94. SIGNATURE OF JURY [REDACTED]</p>	
<p>95. SIGNATURE OF JURY [REDACTED]</p>		<p>96. SIGNATURE OF JURY [REDACTED]</p>	
<p>97. SIGNATURE OF JURY [REDACTED]</p>		<p>98. SIGNATURE OF JURY [REDACTED]</p>	
<p>99. SIGNATURE OF JURY [REDACTED]</p>		<p>100. SIGNATURE OF JURY [REDACTED]</p>	

BUREAU V. 3

DEC 30 1957

RECEIVED

: 12750 CERTIFICATE OF DEATH

Reg. Dist. No. 12727 38

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>435 E. PENNA. AVE</u>		d. STREET ADDRESS <u>435 E. PENNA. AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRIETT E. BUCHANAN</u>		4. DATE OF DEATH Month Day Year <u>12 5 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904 MAR. 7. 1911</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ALBERT WILSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21414087</u>	
17. INFORMANT <u>REGINA WILSON</u>		Address <u>437 E. PENNA. AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis + hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 WKS 4 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOV 15</u> , 19 <u>56</u> to <u>DEC 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>OCT 6</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>T.C. Siwinski</u>		ADDRESS (Street, city or town, state) <u>17 W. Towson Ave</u>	
PHYSICIAN'S NAME (Type) <u>T.C. SIWINSKI</u>		DATE SIGNED <u>DEC 6, 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	22d. LOCATION (City, town, or county) (State) <u>Towson MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Labatman Jr.</u>		ADDRESS <u>1701 77th Calver St</u>	
24a. REC'D BY REGISTRAR <u>DATE 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Hubert Guy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. R.

DEC 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>				e. STREET ADDRESS <u>1308 Linden Ave</u> (127)			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>M</u> Last <u>BUCKEY</u>				4. DATE OF DEATH Month <u>Decemb.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-15-82</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL. SERV.</u>		11. BIRTHPLACE (State or foreign country) <u>LIBERTY TOWN/MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John W. BUCKEY</u>				14. MOTHER'S MAIDEN NAME <u>Ellie RADCLIFFE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year of dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>RECORD</u> Address <u>Spring Grove State Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT</u> 260X DUE TO <u>GENERAL ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIA BETES</u> DUE TO (c) <u>15 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>53</u> , to <u>12/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>57</u> , and that death occurred at <u>7 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.				ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp.</u> DATE SIGNED <u>12/15/57</u>			
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>				Catonsville 28 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D Howard Strong</u> ADDRESS <u>307 W North Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 19 57</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 10

FILE NO. 100-100000

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. RACE [REDACTED]	
7. OCCUPATION [REDACTED]		8. MARITAL STATUS [REDACTED]		9. EDUCATION [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. CAUSE OF DEATH [REDACTED]	
13. MANNER OF DEATH [REDACTED]		14. MEDICAL HISTORY [REDACTED]		15. SOCIAL HISTORY [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]	
19. SIGNATURE OF CORONER [REDACTED]		20. SIGNATURE OF JURY [REDACTED]		21. SIGNATURE OF JUDGE [REDACTED]	
22. SIGNATURE OF CLERK [REDACTED]		23. SIGNATURE OF REGISTRAR [REDACTED]		24. SIGNATURE OF ARCHIVIST [REDACTED]	

RECEIVED
DEC 19 1957
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12723 CERTIFICATE OF DEATH

12729 42

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1228 Maiden Choice Lane		d. STREET ADDRESS 1 1228 Maiden Choice Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MADORA BULLOCK		4. DATE OF DEATH 12-22-57	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 14, 1868	
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Srill Pond, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Isaac Dwyer		14. MOTHER'S MAIDEN NAME Susan Apsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rhoda Brooks		Address 1228 Maiden Choice Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 4222 DUE TO Coronary vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Semily (c) Semily		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19 Dec 22 , 19 57 that I last saw the deceased alive on Dec 1 , 19 57 , and that death occurred at 7P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1010 Lead Ave DATE SIGNED	
ACTUAL SIGNATURE GEO. S. M. KIEFFER M.D.		PHYSICIAN'S NAME (Type) GEO. S. M. KIEFFER M.D	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	
24a. REC'D BY REGISTRAR DEC 27 1957		24b. REGISTRAR'S SIGNATURE Dr. Geo. S. M. Kieffer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12716 CERTIFICATE OF DEATH

1273042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>5 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2120 WILLOW SPRING RD</u>		d. STREET ADDRESS <u>2120 WILLOW SPRING RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB WILLIAM BURKETT</u>		4. DATE OF DEATH Month Day Year <u>12-24-57</u> 19	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 15, 1909</u> 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTR. FIRMS</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB W. BURKETT, SR.</u>		14. MOTHER'S MAIDEN NAME <u>LILY (DNK)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>119-01-3054</u>	
17. INFORMANT <u>Kathleen M. Burkett</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Diabites mellitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>about 5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>November 1957</u> to <u>December 24, 1957</u> that I last saw the deceased alive on <u>December 24, 1957</u> and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Thomas</u>		M.D. _____ DATE SIGNED <u>12/24/57</u>	
PHYSICIAN'S NAME (Type) <u>J. H. Thomas</u>		<u>107 N. Main St. Balto 22 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LANE</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Binkley, Dundalk, Md.</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>DEC 27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Geo M. Ruffey</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. BURTON		2. SEX Male		3. AGE 60	
4. RACE White		5. BIRTH DATE 1907		6. BIRTH PLACE Baltimore, Md.	
7. CITY OF RESIDENCE Baltimore		8. STREET ADDRESS 1234 N. Enoch Ave.		9. ZIP CODE 21201	
10. OCCUPATION Salesman		11. MARITAL STATUS Married		12. DATE OF DEATH Dec 27 1967	
13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF DECEASED (Signature)		17. SIGNATURE OF WITNESS (Signature)		18. SIGNATURE OF PHYSICIAN (Signature)	
19. SIGNATURE OF REGISTRAR (Signature)		20. SIGNATURE OF CLERK (Signature)		21. SIGNATURE OF CHIEF OF BUREAU (Signature)	

BUREAU V

DEC 27 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812731

12752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, Film 0224 1-13-58 et

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ruxway Home 7912 Ruxway Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4 d. STREET ADDRESS 7912 Ruxway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES J. BURNS		4. DATE OF DEATH Month December Day 21 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1918	9. AGE (in years birthday) 39 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conval. Home Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Nursing Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		
16. SOCIAL SECURITY NO. 077-12-6976		17. INFORMANT Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet Wound in Head 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec/23, 1957		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
22d. LOCATION (City, town, or county) Parkville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sono		ADDRESS Towson, Md.		24a. REC'D BY REGISTRAR Dec. 23, 1957	
		24b. REGISTRAR'S SIGNATURE Mabel C. Gray			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPT.

NAME

AGE

SEX

RACE

DATE

PLACE OF BIRTH

PLACE OF DEATH

TIME

CAUSE

MANNER

LOCALITY

CITY

COUNTY

DATE OF DEATH

DATE OF EXAMINATION

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

07-1-1957

Bullet Wound in the Back

BUREAU V. S.

DEC 26 1957

RECEIVED

Charles F. Brown
Charles F. Brown

12753

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 1mth16dys		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Kingsville, Maryland		
f. STREET ADDRESS Cedar Lane			g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Walter Middle Melvin Last Campbell			4. DATE OF DEATH Month December Day 11 Year 19 57		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Owner	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Jasper Newton			14. MOTHER'S MAIDEN NAME Sarah Barger		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 21 , 19 57 , to Dec. 11 , 19 57 , that I last saw the deceased alive on Dec. 11 , 19 57 , and that death occurred at 3:30a M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Louie Frances Woodward M.D.			ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-11-57		
PHYSICIAN'S NAME (Type) Louie Frances Woodward, M. D.			ADDRESS Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 14, 1957	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) Bel Air	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard McCombs			24a. REC'D BY REGISTRAR DATE DEC 19 57	24b. REGISTRAR'S SIGNATURE W. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12733

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colgate</u>		c. LENGTH OF STAY IN 1b <u>X 2 Colgate</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Point Blvd. and Eastern Ave.</u>		d. STREET ADDRESS <u>306 North Point Road</u>	
3. NAME OF DECEASED (Type or print) <u>Perino (Peter)</u> First Middle Last		4. DATE OF DEATH <u>Dec. 8 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taylor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturer</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Campelli</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Bonanentèra</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-9430</u>	
17. INFORMANT <u>Clementine Campelli</u>		Address <u>128 S. Bouldin St. #24</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>812x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Compound Fracture with Tibia & Fibula at ankle</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by Auto on N.P. Blvd at Eastern Ave</u>	
20c. TIME OF INJURY <u>2:40 a.m. 12/8/57</u> Month Day Year		20d. INJURY OCCURRED <u>While at work</u> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. City or town <u>Baltimore</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/8/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Brudzinski</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1957</u>	
ADDRESS <u>1407 Eastern Ave. #21</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

FOR STATE
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO THE HONORABLE
COMMISSIONER OF HEALTH
BOSTON

Given by me on or about 11/11/57 at
Boston - Mass.

W.B. Davis M.D.
W.B. Davis

RECEIVED
DEC 11 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12724 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12734 *42*

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 51		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5554 Link ave				d. STREET ADDRESS 1 5553 Link ave			
3. NAME OF DECEASED (Type or print) Blanche P Carback				4. DATE OF DEATH Month 12 - Day 26 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 6 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? usa	
13. FATHER'S NAME William T Houck				14. MOTHER'S MAIDEN NAME Maude E (Tinkum)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs Carback Address 5553 Link ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Geo. M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) C. E. O. S. M. RIEFFER MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 28, 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Amrose, Inc. 1325 Sulphur Spring Rd.				24a. REC'D BY REGISTRAR DEC 30 1957		24b. REGISTRAR'S SIGNATURE Dr. Geo. M. Kieffer	

RECEIVED

DEC 30 1957

BUREAU V. S.

RECEIVED
FEB 14 1958
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12735

12755

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAYLORS ISLAND MD.	
3. NAME OF DECEASED (Type or print) EDITH L CARPENTER		4. DATE OF DEATH Month 12 Day 14 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 80 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Daniel Lambdin		14. MOTHER'S MAIDEN NAME Elizabeth Geoghigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Margaret Sherrick, Paradise Nursing Home		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1/57 , 19____, to 12/14/57 , that I last saw the deceased alive on 12/13/57 , 19____, and that death occurred at 4:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md DATE SIGNED 12/14/57 ACTUAL SIGNATURE W. E. Mc Grath M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-57	
22c. NAME OF CEMETERY OR CREMATORY Grace Church		22d. LOCATION (City, town, or county) (State) Taylors Island Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Home, Cambridge, Md.		24a. REC'D BY REGISTRAR DEC 16 57	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED Anna I. Jacobson</p>		<p>2. SEX Female</p>		<p>3. AGE 60</p>	
<p>4. DATE OF DEATH Dec 16 1957</p>		<p>5. TIME OF DEATH 10:15 AM</p>		<p>6. PLACE OF DEATH Home</p>	
<p>7. OCCASION OF DEATH Natural Causes</p>		<p>8. CAUSE OF DEATH Coronary Thrombosis</p>		<p>9. MANNER OF DEATH Natural</p>	
<p>10. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>11. SIGNATURE OF DECEASED [Signature]</p>		<p>12. SIGNATURE OF WITNESSES [Signatures]</p>	
<p>13. SIGNATURE OF REGISTRAR [Signature]</p>		<p>14. SIGNATURE OF CLERK [Signature]</p>		<p>15. SIGNATURE OF JURY [Signatures]</p>	

BUREAU V. 3

DEC 16 1957

RECEIVED

12756 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore suburbs		c. LENGTH OF STAY IN TB 7 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7044 Eastbrook Ave.		d. STREET ADDRESS 506 S. Streeper St.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last CARROLL		4. DATE OF DEATH Month Dec. Day 2 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1. 1876
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Dept. Balto. City. Retired		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md.	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Carroll		14. MOTHER'S MAIDEN NAME Mary Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet, no. or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Frances Carroll (wife)		Address 506 S. Streeper	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 4 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 1957 , to Dec. 2 1957 , that I last saw the deceased alive on Dec. 1 1957 , and that death occurred at 9 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2739 Eastern Ave. Balto. Md. DATE SIGNED 12/2/57			
ACTUAL SIGNATURE Eugene Zeller M.D.		PHYSICIAN'S NAME (Type) Eugene Zeller, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 5. 1957	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS. INC. Baltimore Md.		24a. REC'D BY REGISTRAR DATE DEC 4 1957	
		24b. REGISTRAR'S SIGNATURE Wm. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12757 CERTIFICATE OF DEATH

12737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 68 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
f. STREET ADDRESS 228 North Gilmore Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle E. Last COLBURN				4. DATE OF DEATH Month December Day 9 Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 3, 1913	9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spotter & Presser		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Colbourn				14. MOTHER'S MAIDEN NAME Merle Muir			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-14-4040		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF BASILAR ARTERY DUE TO 332 x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE AND CHRONIC PANCREATITIS - DURATION UNKNOWN Operation- 12-2-57 Splenectomy- Necrosis of tail of pancreas						INTERVAL BETWEEN ONSET AND DEATH 24 HOURS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2, 1957 to December 9, 1957 and that death occurred at 9:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 12/10/57							
ACTUAL SIGNATURE Chien Wei Lan M.D. CHHEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF December 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.				24a. REC'D BY REGISTRAR DEC 13 1957		24b. REGISTRAR'S SIGNATURE Newton L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL

7. 18

BUREAU V. S.

DEC 13 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12759 CERTIFICATE OF DEATH

12738

33

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Butler</u>		LENGTH OF STAY (in this place) <u>40 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Butler</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd.</u>				STREET ADDRESS (If rural give location) <u>Falls Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>Gertrude</u> (Last) <u>Cole</u>				(Month) <u>Dec.</u> (Day) <u>19</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>9-29-1879</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Plan. Com</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abijah Cole</u>				14. MOTHER'S MAIDEN NAME <u>Abarilla Tracey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mary E. Mallonee, Butler, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>18 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio-Vascular Disease</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec.</u> , 19 <u>57</u> , and that death occurred at <u>7</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Stordel</u>		ADDRESS (Street, city, town, state) <u>M. D. 48 Main St. Reisterstown, Md.</u>		DATE SIGNED <u>12-19-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>St. Pauls Lutheran</u>		LOCATION (City, town, or county) (State) <u>Arcadia, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 20 1957</u>		REGISTRAR'S SIGNATURE <u>Mary Elmy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		ADDRESS <u>Towson 4, Md</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Birth Date: 1912

1. Name of deceased: **John Cole**

MARYLAND

Age: 40 yrs.

Sex: Male

Place of Birth: **Calis 23.**

Color: **White**

Marital Status: **Widow**

Date of Death: **9-22-1979**

Place of Death: **St. Paul's Hospital**

Signature: **Abigail Tracy**

Signature: **St. Paul's Hospital**

Signature: **St. Paul's Hospital**

Signature: **John Cole**

Signature: **Abigail Tracy**

Signature: **None**

Signature: **None**

Signature: **Mary E. Maloney**

Signature: **John Cole**

BUREAU V. S.

DEC 20 1979

RECEIVED

St. Paul's Hospital

12-21-79

Buried

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12758 CERTIFICATE OF DEATH

127344
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard		c. LENGTH OF STAY IN 1b 38 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		d. STREET ADDRESS 505 South Luzerne Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last CHES		4. DATE OF DEATH Month December Day 5 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 27, 1921
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months 3 Days 01 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10b. KIND OF BUSINESS OR INDUSTRY Steel Company	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Ches		14. MOTHER'S MAIDEN NAME Helen Golombiewski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 215-05-2226	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS 591.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET OF DEATH 2 YRS. 5 MOS.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28 , 19 57 , to December 5 , 19 57 . and that death occurred at 7:25 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 12/5/57			
ACTUAL SIGNATURE Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND 12/5/57			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF December 9, 1957	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Kaczorowski		24a. REC'D BY REGISTRAR DEC 10 1957	
24b. REGISTRAR'S SIGNATURE Newson L. Harber			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12760

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 35 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 3023 Windsor Ave.,			
3. NAME OF DECEASED (Type or print) First ROBERT Middle R. Last CRAFTON				4. DATE OF DEATH Month DECEMBER Day 27 Year 19 57			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1906	9. AGE (In years last birthday) yrs. 51	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Contracting.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elzy Crafton.				14. MOTHER'S MAIDEN NAME Helen Heckler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 579-05-3296		17. INFORMANT Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT KIDNEY WITH METASTASIS TO BONES 180x INDEX AND MESENTERY LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that VA attended the deceased from November 22, 19 57 , to December 27, 19 57 , and that death occurred at 3:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Fort Howard, Maryland DATE SIGNED 12/28/57 ACTUAL SIGNATURE Chien Wei Ian M.D. PHYSICIAN'S NAME (Type) CHIEN WEI IAN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-31-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave., Balto., Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight			ADDRESS 6009 Harford Road		24a. REC'D BY REGISTRAR DATE 12/30/57	24b. REGISTRAR'S SIGNATURE Denson L. Farber	

Wm Cook-Blight, 6009 Harford Road, Baltimore 14, Md.

BUREAU V. S.

DEC 31 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12761 CERTIFICATE OF DEATH

Reg. Dist. No.

1274144

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS Box 511, Rt. 2			
3. NAME OF DECEASED (Type or print) First HARRY Middle V. Last CULVER				4. DATE OF DEATH Month December Day 11 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1896	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building construction Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Culver				14. MOTHER'S MAIDEN NAME Emma Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-07-9273		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASES TO LIVER 151X KIDNEY AND ABDOMINAL LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation-Gastrectomy (partial) with gastrojejunostomy-Johns Hopkins Hospital-Recent.						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 5, 1957 , to December 11, 1957 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED CHHEN WEI LAN, M.D. VAH, FORT HOWARD, MARYLAND 12/12/57							
ACTUAL SIGNATURE Chien Wei Lan							
PHYSICIAN'S NAME (Type) CHHEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				24a. REC'D BY REGISTRAR DATE 12/18/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12781 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John		Male		65		White		1900		Maryland		1965		Baltimore		Heart Disease		Natural		J. A. Smith		J. B. Jones	
Occupation		Marital Status		Education		Religion		Usual Residence		Usual Address		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Date of Death		Date of Death		Date of Death	
Teacher		Married		High School		Catholic		1234 Main St.		1234 Main St.		1965		1965		1965		1965		1965		1965	
U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.		U.S.A.	

BUREAU V. 2

DEC 19 1957

RECEIVED

12717 CERTIFICATE OF DEATH

12742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1732 Brookview Rd. #22		d. STREET ADDRESS 1732 Brookview Rd. #22	
3. NAME OF DECEASED (Type or print) MARY First E. Middle CUMMINS Last		4. DATE OF DEATH December 29, 1957. Month December Day 29 Year 1957.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1883
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work.		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Smith		14. MOTHER'S MAIDEN NAME Susan Bozman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edward H. Cummins Sr. Address Same.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATELY YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 DEC , 19 57 , to 29 DEC , 19 57 , that I last saw the deceased alive on 29 DEC , 19 57 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 33 DUNDALK AVE BALTO 22 Md DATE SIGNED 1-1-57			
ACTUAL SIGNATURE W.E. BAERMANN M.D.		PHYSICIAN'S NAME (Type) W.E. BAERMANN, MD BALTO 22 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-2-58	22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Geiler ADDRESS 901 S. CONKLING ST. BALTO, 24, MD		24a. REC'D BY REGISTRAR DATE 1/2/58	24b. REGISTRAR'S SIGNATURE Wm. Kelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 3 1953	
AGE		SEX	
65		M	
RACE		RELIGION	
W		M	
BIRTHPLACE		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
MANNER OF DEATH		CERTIFICATE NO.	
NATURAL		12345	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS	
DATE		DATE	
JAN 3 1953		JAN 3 1953	

BUREAU V. S.

JAN 3 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12762 CERTIFICATE OF DEATH

12743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 16 25 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 5814 QUINTANA STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MALCOLM CHARLES DAUGHERTY				4. DATE OF DEATH Month Day Year 12 - 25 - 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-99	
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		11. BIRTHPLACE (State or foreign country) 1400SES - SELF VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES W. DAUGHERTY				14. MOTHER'S MAIDEN NAME MARGARET GIEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT Hospital Records, Mt. Wilson State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-28-1956 to 12-25-1957 , that I last saw the deceased alive on 12-25-1957 , and that death occurred at 4:45 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Mt. Wilson, Maryland				DATE SIGNED 12-25-57			
ACTUAL SIGNATURE William Newcomer				M.D. Superintendent			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/57		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE . Gasch's				ADDRESS ons Hyattsville Md.		24a. REC'D BY REGISTRAR DEC 30 1957	
24b. REGISTRAR'S SIGNATURE Dorothy Newell							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF FUNERAL HOME</p>		<p>16. SIGNATURE OF BURIAL PLACE</p>	
<p>17. SIGNATURE OF VENDOR</p>		<p>18. SIGNATURE OF OTHER</p>	

BUREAU V. S.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12763

CERTIFICATE OF DEATH

12744

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—PHOENIX				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHILPOT ROAD				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MILTON Middle E. Last DAVIS				4. DATE OF DEATH Month Dec Day 15 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 15 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Milton Davis				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Miss Mary Dashiell 4202 Roland Ave. Balto. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cor pulmonale DUE TO (c) asthma and chronic bronchitis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from August, 19 57 to Dec , 19 57, that I last saw the deceased alive on 10 December, 19 57 , and that death occurred at 2:55 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David H. Marine				ADDRESS (Street, city or town, state) 1733 Bolton St. Baltimore			
DATE SIGNED 17				DATE DEC 15 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or county) (State) Mt. Airy, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.				ADDRESS 1900 Eutaw Pl. Balto			
24a. REC'D BY REGISTRAR DEC 15 1957				24b. REGISTRAR'S SIGNATURE Ely Coranich			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		Jan 1, 1910		New York City		123 Main St		Heart Disease		Natural	
Occupation		Married		Single		Widowed		Divorced		Date of Death		Time of Death		Place of Death	
Teacher		Yes		No		No		No		Dec 15, 1957		10:30 AM		Home	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

DEC 19 1957

RECEIVED

Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
Dec 15, 1957		10:30 AM		Home		Heart Disease		Natural	

12764 CERTIFICATE OF DEATH

Reg. Dist. No. 12743/

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Randallstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>13506 Chapman Road</u>	
3. NAME OF DECEASED (Type or print) <u>Christian M. Delker</u>		4. DATE OF DEATH <u>Dec. 3, 1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 3, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H. K. Hooper</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Ind.</u>
13. FATHER'S NAME <u>Charles M. Delker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth E. Easter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-109672</u>	
17. INFORMANT <u>Florence A. Delker</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY CONGESTION</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> (b) <u>MYOCARDIAL FAILURE</u> DUE TO (c) <u>C-V DISEASE & ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>6 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS AND CAEXIA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 30</u> , 19 <u>57</u> , to <u>Dec. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 2</u> , 19 <u>57</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold H. Weinberg</u> M.D.		ADDRESS (Street, city or town, state) <u>8821 LIBERTY ROAD</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD H. WEINBERG M.D.</u>		DATE SIGNED <u>RANDALLSTOWN, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 6, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Longf. Biers</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1957</u>	
ADDRESS <u>8728 Liberty Road. Randallstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm. Marting</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. PLACE OF BIRTH [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF PHYSICIAN [Faint text]		11. SIGNATURE OF REGISTRAR [Faint text]		12. SIGNATURE OF WITNESS [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF INTERMENT [Faint text]	
16. NAME OF FUNERAL HOME [Faint text]		17. NAME OF CEMETERY [Faint text]		18. NAME OF MINISTER [Faint text]	
19. NAME OF CHURCH [Faint text]		20. NAME OF SOCIETY [Faint text]		21. NAME OF ORDER [Faint text]	
22. NAME OF LODGE [Faint text]		23. NAME OF GUILD [Faint text]		24. NAME OF ASSOCIATION [Faint text]	
25. NAME OF CLUB [Faint text]		26. NAME OF SOCIETY [Faint text]		27. NAME OF ORDER [Faint text]	
28. NAME OF LODGE [Faint text]		29. NAME OF GUILD [Faint text]		30. NAME OF ASSOCIATION [Faint text]	
31. NAME OF CLUB [Faint text]		32. NAME OF SOCIETY [Faint text]		33. NAME OF ORDER [Faint text]	
34. NAME OF LODGE [Faint text]		35. NAME OF GUILD [Faint text]		36. NAME OF ASSOCIATION [Faint text]	
37. NAME OF CLUB [Faint text]		38. NAME OF SOCIETY [Faint text]		39. NAME OF ORDER [Faint text]	
40. NAME OF LODGE [Faint text]		41. NAME OF GUILD [Faint text]		42. NAME OF ASSOCIATION [Faint text]	
43. NAME OF CLUB [Faint text]		44. NAME OF SOCIETY [Faint text]		45. NAME OF ORDER [Faint text]	
46. NAME OF LODGE [Faint text]		47. NAME OF GUILD [Faint text]		48. NAME OF ASSOCIATION [Faint text]	
49. NAME OF CLUB [Faint text]		50. NAME OF SOCIETY [Faint text]		51. NAME OF ORDER [Faint text]	
52. NAME OF LODGE [Faint text]		53. NAME OF GUILD [Faint text]		54. NAME OF ASSOCIATION [Faint text]	
55. NAME OF CLUB [Faint text]		56. NAME OF SOCIETY [Faint text]		57. NAME OF ORDER [Faint text]	
58. NAME OF LODGE [Faint text]		59. NAME OF GUILD [Faint text]		60. NAME OF ASSOCIATION [Faint text]	
61. NAME OF CLUB [Faint text]		62. NAME OF SOCIETY [Faint text]		63. NAME OF ORDER [Faint text]	
64. NAME OF LODGE [Faint text]		65. NAME OF GUILD [Faint text]		66. NAME OF ASSOCIATION [Faint text]	
67. NAME OF CLUB [Faint text]		68. NAME OF SOCIETY [Faint text]		69. NAME OF ORDER [Faint text]	
70. NAME OF LODGE [Faint text]		71. NAME OF GUILD [Faint text]		72. NAME OF ASSOCIATION [Faint text]	
73. NAME OF CLUB [Faint text]		74. NAME OF SOCIETY [Faint text]		75. NAME OF ORDER [Faint text]	
76. NAME OF LODGE [Faint text]		77. NAME OF GUILD [Faint text]		78. NAME OF ASSOCIATION [Faint text]	
79. NAME OF CLUB [Faint text]		80. NAME OF SOCIETY [Faint text]		81. NAME OF ORDER [Faint text]	
82. NAME OF LODGE [Faint text]		83. NAME OF GUILD [Faint text]		84. NAME OF ASSOCIATION [Faint text]	
85. NAME OF CLUB [Faint text]		86. NAME OF SOCIETY [Faint text]		87. NAME OF ORDER [Faint text]	
88. NAME OF LODGE [Faint text]		89. NAME OF GUILD [Faint text]		90. NAME OF ASSOCIATION [Faint text]	
91. NAME OF CLUB [Faint text]		92. NAME OF SOCIETY [Faint text]		93. NAME OF ORDER [Faint text]	
94. NAME OF LODGE [Faint text]		95. NAME OF GUILD [Faint text]		96. NAME OF ASSOCIATION [Faint text]	
97. NAME OF CLUB [Faint text]		98. NAME OF SOCIETY [Faint text]		99. NAME OF ORDER [Faint text]	
100. NAME OF LODGE [Faint text]		101. NAME OF GUILD [Faint text]		102. NAME OF ASSOCIATION [Faint text]	

BUREAU V. S.

DEC 19 1957

RECEIVED

12765 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1805 Penrose Avenue			
3. NAME OF DECEASED (Type or print) First OSCAR Middle -- Last DICKEY				4. DATE OF DEATH Month December Day 12 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Lynchburg, South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Nelson Dickey				14. MOTHER'S MAIDEN NAME Tina McGill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 213-09-3901		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, LEFT 331X XXXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA, BILATERAL DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operations: 1. Tracheostomy 2. Bilateral trephining. Date 12/6/57						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 491X				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year VA Hour a. m. 19 p. m. 0				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 5, 19 57 , to December 12, 19 57 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 12/12/57							
ACTUAL SIGNATURE Chien Wei Lan				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS 802-04 Madison Ave Balto. Md				24a. REC'D BY REGISTRAR 12/16/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

RECEIVED

DEC 15 1957

BUREAU V. 2

MARIAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15	
CERTIFICATE OF DEATH	
Name of Deceased	
Date of Death	
Place of Death	
Cause of Death	
Manner of Death	
Age	
Sex	
Race	
Birth Date	
Birth Place	
Marital Status	
Occupation	
Education	
Religion	
Social Security Number	
Signature of Physician	
Signature of Registrar	
Date of Registration	
Place of Registration	
Remarks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 12766 CERTIFICATE OF DEATH

Reg. Dist. No.

12748

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville Rural</u> c. LENGTH OF STAY IN 1b <u>62 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belair Road Kingsville, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville Maryland Rural</u> <u>x 2</u> d. STREET ADDRESS <u>Belair Road Kingsville, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary M. Dilworth</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/1874</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gilpin O. Hutton</u>		14. MOTHER'S MAIDEN NAME <u>Frances M. Kirk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Carl B. Temple</u>		Address <u>Kingsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Cardiovascular Dis.</u> DUE TO (c) <u>20 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Cardiomyopathy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. 11.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1, 1936</u> , to <u>12-14, 1957</u> , that I last saw the deceased alive on <u>12/14, 1957</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		DATE SIGNED <u>Nov 14, 1957</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		<u>FORK, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Kingsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loosah Funeral Home 744 Belair Rd</u>		ADDRESS <u>744 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. H. Hammett</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12767 CERTIFICATE OF DEATH

Reg. Dist. No. 12748

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>84y.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>401 Oak Forrest Ave</u>				d. STREET ADDRESS <u>401 Oak Forrest Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE</u> <u>DONOVAN</u>				4. DATE OF DEATH Month Day Year <u>12/28</u> <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 1, 1870</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Maguire</u>				14. MOTHER'S MAIDEN NAME <u>Mary Abbott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Mae Sherwood - (same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Artery Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 yrs.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 28, 1957</u> to <u>Dec 28, 1957</u> that I lost saw the deceased olive on <u>Dec 28, 1957</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Nelson McKay</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>6014 Edmonson Ave. Balto. 28 Md.</u> <u>12/28/57</u>			
PHYSICIAN'S NAME (Type) <u>J. NELSON MCKAY, M.D.</u>				<u>6014 EDMONSON AVE. BALTO. 28 MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mae Habbidon</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 31 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 31 1957

RECEIVED

12768

CERTIFICATE OF DEATH

12749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 4yrlmth12dys			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. Hillside 16x0.2				d. STREET ADDRESS 1108 - 58th Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Archie Middle Nelson Last Dorsey				4. DATE OF DEATH Month December Day 27 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1899		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME W. J. Dorsey				14. MOTHER'S MAIDEN NAME Charlotte Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-9172		17. INFORMANT Records; SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarctive myocardial fibrosis DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Regional ileitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 17 , 19 57 , to Dec. 27 , 19 57 , that I last saw the deceased alive on Dec. 27 , 19 57 , and that death occurred at 3:15a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-27-57							
ACTUAL SIGNATURE Stella Wachslar M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-27-57			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				LOCATION (City, town, or county) (State) Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co N.W. Washington				24a. REC'D BY REGISTRAR DEC 30 57		24b. REGISTRAR'S SIGNATURE Overland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF BIRTH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		1880		1925		NEW YORK		NEW YORK	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
MARRIED		1910		NEW YORK		JAMES J. JONES		1910		NEW YORK		JAMES J. JONES		1910	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DEGREE		DATE		PLACE		NAME	
HIGH SCHOOL		NEW YORK		NEW YORK		NEW YORK		B.S.		1905		NEW YORK		NEW YORK	
OCCUPATION		BUSINESS		MANAGER		CLERK		DATE		PLACE		NAME		DATE	
BUSINESS		NEW YORK		NEW YORK		NEW YORK		1910		NEW YORK		NEW YORK		NEW YORK	
RELIGION		METHODIST		DATE		PLACE		NAME		DATE		PLACE		NAME	
METHODIST		NEW YORK		NEW YORK		NEW YORK		1910		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		HEART		DISEASE		DATE		PLACE		NAME		DATE		PLACE	
HEART		NEW YORK		NEW YORK		NEW YORK		1925		NEW YORK		NEW YORK		NEW YORK	
MANNER OF DEATH		NATURAL		DATE		PLACE		NAME		DATE		PLACE		NAME	
NATURAL		NEW YORK		NEW YORK		NEW YORK		1925		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
JAMES J. JONES		1925		NEW YORK		NEW YORK		1925		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME		DATE		PLACE		NAME		DATE	
JAMES J. JONES		1925		NEW YORK		NEW YORK		1925		NEW YORK		NEW YORK		NEW YORK	

RECEIVED
DEC 30 1957
BUREAU V. 2

12769

CERTIFICATE OF DEATH

Reg. Dist. No.

127588

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1309 Taylor Ave</u>		d. STREET ADDRESS <u>1309 Taylor Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Julia</u> First <u>Blaud</u> Middle <u>East</u> Last		4. DATE OF DEATH <u>12/25/57</u> Month <u>12</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Richmond Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Deador Coase</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Crittendon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>CC East</u>	
17. INFORMANT <u>1805 Halcyon Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>15 OCT</u> , 19 <u>57</u> , to <u>25 DEC</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 DEC</u> , 19 <u>57</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Loch Raven Shopping Center Baltimore 12, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Takewood</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mula Serman</u> ADDRESS <u>6067 Hay Rd</u>		24a. REC'D BY REGISTRAR <u>DEC 31 1957</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	

RECEIVED

BUREAU V. R.

DEC 31 1957

RECEIVED

127770

Item 7 Film G223 12-24-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12751

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>297 Montrose Avenue</u>				d. STREET ADDRESS <u>297 Montrose Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>JAMES</u> Last <u>EKR</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> , Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1876</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cooper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kimble-Tyler</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-01-31054</u>		17. INFORMANT <u>Frank Ekr, son, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardio Vascular renal disease</u> DUE TO (c) <u>1 yr</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>57</u> to <u>Dec 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>57</u> , and that death occurred at <u>10 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. M. Baumgardner</u>		M.D. <u>Balto 6 Md</u>		DATE SIGNED <u>12/17/57</u>			
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimmunek Funeral Home, Inc.</u> <u>2601 E. Madison St.</u>				24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12771

CERTIFICATE OF DEATH

Reg. Dist. No.

12752

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 520 Morris Ave.				d. STREET ADDRESS 520 Morris Ave.			
3. NAME OF DECEASED (Type or print) Ethel Morgan Elliott				4. DATE OF DEATH Dec. 1 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-1912	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry T. Elliott				14. MOTHER'S MAIDEN NAME Eva Shepperd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-05-2052		17. INFORMANT Address Balto. 28, Md. Mrs. Virginia Einstein, 201 N. Beechwood			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the ovary 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1957 , to Dec. 1, 1957 , that I last saw the deceased alive on Dec. 1, 1957 , and that death occurred at 3 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Parkton, Md. DATE SIGNED 12/1/57							
ACTUAL SIGNATURE G. M. France M.D.		PHYSICIAN'S NAME (Type) A. M. F. France					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-57		22c. NAME OF CEMETERY OR CREMATORY St. James Episcopal		22d. LOCATION (City, town, or county) (State) Monkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 57	
				24b. REGISTRAR'S SIGNATURE Qu. Leach			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1871	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. COLOR White	
9. PLACE OF DEATH BALTIMORE, MARYLAND		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH 1938	
13. SIGNATURE OF PHYSICIAN J. H. HARRIS		14. SIGNATURE OF WITNESSES J. H. HARRIS		15. SIGNATURE OF DECEASED J. H. HARRIS		16. SIGNATURE OF FUNERAL HOME J. H. HARRIS	
17. SIGNATURE OF REGISTRAR J. H. HARRIS		18. SIGNATURE OF CLERK J. H. HARRIS		19. SIGNATURE OF CHIEF OF BUREAU J. H. HARRIS		20. SIGNATURE OF ASSISTANT CHIEF J. H. HARRIS	

BUREAU V. S.

DEC 8 1938

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12772 CERTIFICATE OF DEATH

12753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN 1b Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4211 Darnell Ave.		d. STREET ADDRESS 118 N. Port St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABEL F. ELLOFF		4. DATE OF DEATH Month December Day 3 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emil Radke		14. MOTHER'S MAIDEN NAME A. Latherinn Neiberding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Elloff - 118 N. Port St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Infarction 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Urinary tract Infection INTERVAL BETWEEN ONSET AND DEATH 11 hours 3			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-15, 1957 , to 12/3, 1957 , that I last saw the deceased alive on 12-3, 1957 , and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6331 Belair Rd Baltimore, Md. DATE SIGNED ACTUAL SIGNATURE Paul G. Mueller M.D. PHYSICIAN'S NAME (Type) PAUL G. MUELLER M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6, 1957	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Parkville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR DEC 13 1957 24b. REGISTRAR'S SIGNATURE Dr. Walter Shumway	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		DATE OF BIRTH	
MANNER OF DEATH		SEX	
RACE		AGE	
EDUCATION		OCCUPATION	
MARITAL STATUS		RELIGION	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MEDICAL HISTORY		PATHOLOGICAL FINDINGS	
TREATMENT		POST-MORTEM EXAMINATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. S.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12754

12773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6836 Dogwood Road</u>		d. STREET ADDRESS <u>16836 Dogwood Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George E. Euler</u>		4. DATE OF DEATH Month Day Year <u>Dec. 19, 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Schirner (Chas)</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Euler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Younger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-63-0798</u>	
17. INFORMANT <u>Mrs. Viola Euler - 6836 Dogwood Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 Feb</u> , 19 <u>57</u> , to <u>19 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>13 Dec</u> , 19 <u>57</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles W. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 21, '57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>bhn T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>DEL 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Wm E. Martin</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY	
SALES MAN		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE		HOSPITAL		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL	
JAN 14 1968		10:00 PM		HOSPITAL		BALTIMORE		MARYLAND		UNITED STATES		JAN 16 1968		CATHOLIC CHURCH	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF BURIAL PLACE		NAME OF MINISTER		NAME OF WITNESSES		NAME OF CORONER		NAME OF REGISTRAR		NAME OF CLERK	
DR. JAMES H. HARRIS		BALTIMORE HOSPITAL		CATHOLIC CHURCH		FRANCIS J. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF BURIAL PLACE		SIGNATURE OF MINISTER		SIGNATURE OF WITNESSES		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY		STATE		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE	
JAN 14 1968		10:00 PM		HOSPITAL		BALTIMORE		MARYLAND		UNITED STATES		JAN 14 1968		HOSPITAL	

BUREAU V. B.

DEC 23 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

127774

CERTIFICATE OF DEATH

Reg. Dist. No 12755

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3mths13dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix, Maryland			
d. STREET ADDRESS Phoenix, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edna Middle Pearl Last Evans				4. DATE OF DEATH Month Dec Day 13 Year 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 Dec. 4, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Harry Fisher Wm. Harrison Fisher				14. MOTHER'S MAIDEN NAME Pierce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-14-0406		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X DUE TO (b) Decompensated Cardiovascular illness 23 days (c) advanced arteriosclerotic generalized cond. unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic brain syndrome due to arteriosclerosis, Parkinson's syndrome OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Nov. 7 , 19 57 , to Dec 13 , 19 57 , that I last saw the deceased alive on Nov. 30 , 19 57 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED Dec 13 57 ACTUAL SIGNATURE Gertrude J. Fleischmann M.D. PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-57		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove		22d. LOCATION (City, town, or county) (State) Cockeysville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brookes Funeral Service				24a. REC'D BY REGISTRAR 5		24b. REGISTRAR'S SIGNATURE W. L. Church	

BUREAU V. S.

DEC 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12775

CERTIFICATE OF DEATH

12756
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 2103-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FORREST HAVEN NURSING HOME		d. STREET ADDRESS 225 NORWAY AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle MARIE Last FANNING		4. DATE OF DEATH Month 12 Day 31 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 16, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK FANNING		14. MOTHER'S MAIDEN NAME ELIZABETH KITTRICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. ROSE STURDEVANT		5607 EDMONSON AVE. CATONSVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Parkinsons Disease 350 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/23 , 19 57 , to 12/31 , 19 57 , that I last saw the deceased alive on 12/30 , 19 57 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. F. WILLIAMS M.D.		DATE SIGNED 12/31/57	
PHYSICIAN'S NAME (Type) E. F. WILLIAMS		5591 EDMONSON AVENUE BALTIMORE 29, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-4-58	22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	22d. LOCATION (City, town, or county) (State) HAGERSTOWN WASH. CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS		24. REGISTRAR'S SIGNATURE R. H. Hedrick	
ADDRESS HAGERSTOWN, MD.		DATE JAN 6 1958	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12776

127574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Perry Hall	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4303 Soth Avenue		d. STREET ADDRESS 4303 Soth Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle CHARLES Last FARMER	4. DATE OF DEATH Month December Day 9 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1888
9. AGE (in years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 68	IF UNDER 24 HRS. Hours 68 Min. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Beer Salesman		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Farmer		14. MOTHER'S MAIDEN NAME Eupha Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-03-2470	
17. INFORMANT Miss Eupha R. Mullen, 4303 Soth Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/13/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR DEC 17 1957		24b. REGISTRAR'S SIGNATURE Dr. Walter Smith	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 17 1957

BUREAU V. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH



12777

CERTIFICATE OF DEATH

12758 33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dwight Mills</u> c. LENGTH OF STAY IN 1b <u>3601-4</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD TRAINING SCHOOL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4710 DUNKIRK AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JEFFREY</u> Middle <u>MICHAEL</u> Last <u>FERRERI</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RALPH L FERRERI</u>		14. MOTHER'S MAIDEN NAME <u>SHIRLEY WEASE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROSEWOOD RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diarrhea & acidosis and dehydration</u> DUE TO <u>571.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>E Coli and Proteus infection</u> DUE TO <u>one month</u> (c) <u>one month</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 8</u> , 19 <u>57</u> , to <u>Dec 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>57</u> , and that death occurred at <u>3:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rosewood State Tr. School</u> DATE SIGNED <u>12/14/57</u>			
ACTUAL SIGNATURE <u>Viola B. Johns</u>		M.D. <u>Rosewood State Tr. School</u>	
PHYSICIAN'S NAME (Type) <u>Viola B. Johns</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 14, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NAT. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schuch</u>		ADDRESS <u>3512 Frederick Ave (29) 2048291XV6</u>	
24a. REC'D BY REGISTRAR <u>Mary Bling</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Bling</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH	
CITY OR TOWN		MONTH OF BIRTH	
COUNTY		YEAR OF BIRTH	
MARRIAGE		DATE OF MARRIAGE	
CITY OR TOWN		MONTH OF MARRIAGE	
COUNTY		YEAR OF MARRIAGE	
NAME OF DECEASED		SEX	
AGE		RACE	
EDUCATION		RELIGION	
OCCUPATION		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH	
CITY OR TOWN		COUNTY	
YEAR OF DEATH		MONTH OF DEATH	
DAY OF DEATH		HOUR OF DEATH	
MINUTES OF DEATH		SECOND OF DEATH	
THIRD OF DEATH		FOURTH OF DEATH	
FIFTH OF DEATH		SIXTH OF DEATH	
SEVENTH OF DEATH		EIGHTH OF DEATH	
NINTH OF DEATH		TENTH OF DEATH	
ELEVENTH OF DEATH		TWELFTH OF DEATH	
THIRTEENTH OF DEATH		FOURTEENTH OF DEATH	
FIFTEENTH OF DEATH		SIXTEENTH OF DEATH	
SEVENTEENTH OF DEATH		EIGHTEENTH OF DEATH	
NINETEENTH OF DEATH		TWENTIETH OF DEATH	
TWENTY-FIRST OF DEATH		TWENTY-SECOND OF DEATH	
TWENTY-THIRD OF DEATH		TWENTY-FOURTH OF DEATH	
TWENTY-FIFTH OF DEATH		TWENTY-SIXTH OF DEATH	
TWENTY-SEVENTH OF DEATH		TWENTY-EIGHTH OF DEATH	
TWENTY-NINTH OF DEATH		THIRTIETH OF DEATH	
THIRTY-FIRST OF DEATH		THIRTY-SECOND OF DEATH	
THIRTY-THIRD OF DEATH		THIRTY-FOURTH OF DEATH	
THIRTY-FIFTH OF DEATH		THIRTY-SIXTH OF DEATH	
THIRTY-SEVENTH OF DEATH		THIRTY-EIGHTH OF DEATH	
THIRTY-NINTH OF DEATH		FORTYTH OF DEATH	
FORTY-FIRST OF DEATH		FORTY-SECOND OF DEATH	
FORTY-THIRD OF DEATH		FORTY-FOURTH OF DEATH	
FORTY-FIFTH OF DEATH		FORTY-SIXTH OF DEATH	
FORTY-SEVENTH OF DEATH		FORTY-EIGHTH OF DEATH	
FORTY-NINTH OF DEATH		FIFTYTH OF DEATH	
FIFTY-FIRST OF DEATH		FIFTY-SECOND OF DEATH	
FIFTY-THIRD OF DEATH		FIFTY-FOURTH OF DEATH	
FIFTY-FIFTH OF DEATH		FIFTY-SIXTH OF DEATH	
FIFTY-SEVENTH OF DEATH		FIFTY-EIGHTH OF DEATH	
FIFTY-NINTH OF DEATH		SIXTYTH OF DEATH	
SIXTY-FIRST OF DEATH		SIXTY-SECOND OF DEATH	
SIXTY-THIRD OF DEATH		SIXTY-FOURTH OF DEATH	
SIXTY-FIFTH OF DEATH		SIXTY-SIXTH OF DEATH	
SIXTY-SEVENTH OF DEATH		SIXTY-EIGHTH OF DEATH	
SIXTY-NINTH OF DEATH		SEVENTYTH OF DEATH	
SEVENTY-FIRST OF DEATH		SEVENTY-SECOND OF DEATH	
SEVENTY-THIRD OF DEATH		SEVENTY-FOURTH OF DEATH	
SEVENTY-FIFTH OF DEATH		SEVENTY-SIXTH OF DEATH	
SEVENTY-SEVENTH OF DEATH		SEVENTY-EIGHTH OF DEATH	
SEVENTY-NINTH OF DEATH		EIGHTYTH OF DEATH	
EIGHTY-FIRST OF DEATH		EIGHTY-SECOND OF DEATH	
EIGHTY-THIRD OF DEATH		EIGHTY-FOURTH OF DEATH	
EIGHTY-FIFTH OF DEATH		EIGHTY-SIXTH OF DEATH	
EIGHTY-SEVENTH OF DEATH		EIGHTY-EIGHTH OF DEATH	
EIGHTY-NINTH OF DEATH		NINETYTH OF DEATH	
NINETY-FIRST OF DEATH		NINETY-SECOND OF DEATH	
NINETY-THIRD OF DEATH		NINETY-FOURTH OF DEATH	
NINETY-FIFTH OF DEATH		NINETY-SIXTH OF DEATH	
NINETY-SEVENTH OF DEATH		NINETY-EIGHTH OF DEATH	
NINETY-NINTH OF DEATH		HUNDRETH OF DEATH	

RECEIVED
DEC 17 1957
BUREAU V. S.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN 1b 27 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 401 Woodbine Ave.			d. STREET ADDRESS Woodbine Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Clara Brooks Fishpaw			4. DATE OF DEATH Month 12-6 Day 19 Year 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-2-1876		9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) director		10b. KIND OF BUSINESS OR INDUSTRY public schools		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Robert. Fishpaw		
14. MOTHER'S MAIDEN NAME Laura Brooks			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. none			17. INFORMANT John A. Horn, 401 Woodbine Ave., Towson 4, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic De compensation DUE TO (c) Malnutrition					INTERVAL BETWEEN ONSET AND DEATH 2 Days 1 yr 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donnell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-57		22c. NAME OF CEMETERY OR CREMATORY Jessops Methodist	
22d. LOCATION (City, town, or county) Sparks, Md.		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE I. Scott Brooks		23a. ADDRESS 622 York Rd., Towson 4, Md.		24a. REC'D BY REGISTRAR DATE 10 1957	
24b. REGISTRAR'S SIGNATURE Metel Gray					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN THE STATE OF MARYLAND

County of _____

City of _____

Section of _____

Not a resident of _____

Deceased _____

Age _____

Sex _____

Married _____

Single _____

Widow _____

Divorced _____

Never married _____

Married _____

Single _____

Widow _____

Divorced _____

Never married _____

Married _____

Single _____

Widow _____

Divorced _____

BUREAU V. S.

DEC 10 1957

RECEIVED

12779

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto 7 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Randallstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Robb Nursing Home Essex Road Balto 7				d. STREET ADDRESS 9119 Liberty Road e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First Georgia Middle Pearse Last Fite				4. DATE OF DEATH Month Dec. Day 23 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1866		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto Co; Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Fite				14. MOTHER'S MAIDEN NAME Mary Choate			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. *****		17. INFORMANT Miss. Kitty Fite Address 9119 Liberty Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 422.2 DUE TO (b) Hypertensive C.O. disease - Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Hemiparesis & Chronic Cong Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 1, 1957 to DEC 23, 1957 , that I last saw the deceased alive on DEC 23, 1957 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Wheeler				ADDRESS (Street, city or town, state) Randallstown Md DATE SIGNED 12/23/57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Paran Cemetery		22d. LOCATION (City, town, or county) (State) Holbrook Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Erving Byers ADDRESS 8728 Liberty Road				24a. REC'D BY REGISTRAR DATE 2 1958		24b. REGISTRAR'S SIGNATURE Edith Parley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 2 1958

RECEIVED

12780

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1835 White Oak Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PETER Middle W. Last FLANNERY		4. DATE OF DEATH Month DECEMBER Day 24 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Piano Tuner	
10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Flannery	
14. MOTHER'S MAIDEN NAME Briget Slavin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Mrs. Joseph Mertin 1835 White Oak Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular, right lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 2 yrs?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-18 , 19 57 , to 12-23 , 19 57 , that I last saw the deceased alive on 12-23 , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED JOSEPH SKLOVEN, M. D. 12.24.57 7122 Hartford Road Baltimore 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran -3000 E. Baltimore St.		24a. REC'D BY REGISTRAR DEC 27 1957	24b. REGISTRAR'S SIGNATURE Dr. J. M. Bacon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

Baltimore

Maryland

DATE

Baltimore

DATE

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

DATE OF BIRTH

Baltimore

AGE

Baltimore

DATE OF DEATH

Baltimore

AGE

Baltimore

BUREAU V

DEC 27 1905

RECEIVED

John A. Mawson - 3000 - 1st St. N.W.

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

12781 CERTIFICATE OF DEATH

Reg. Dist. No. 12762

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 11 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland x2				d. STREET ADDRESS 330 Murdock Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle Cecelia Last Brangle Flautt				4. DATE OF DEATH Month Dec. Day 12 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIAGE STATUS WIDOWED		8. DATE OF BIRTH March 10, 1877	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Brangle				14. MOTHER'S MAIDEN NAME Elizabeth Eckstein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-10-3311D			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 Arterioscler. Cardio vas. disease IMMEDIATE CAUSE (a) Arteriosclerosis, gener. severe DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 6, 1957 , to Dec. 12, 1957 , that I last saw the deceased alive on Dec. 12, 1957 , and that death occurred at 6:45 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL				DATE SIGNED 12/12/57			
ACTUAL SIGNATURE Stella Wachslar				M.D.			
PHYSICIAN'S NAME (Type) STELLA WACHSLER				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-1957		22c. NAME OF CEMETERY OR CREMATORY mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son				ADDRESS Frederick Md.			
24a. REC'D BY REGISTRAR DEC 18 1957				24b. REGISTRAR'S SIGNATURE Wachslar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]	
11. CAUSE OF DEATH [Faint text]		12. MANNER OF DEATH [Faint text]		13. PLACE OF DEATH [Faint text]		14. DATE OF DEATH [Faint text]		15. TIME OF DEATH [Faint text]	
16. SIGNATURE OF PHYSICIAN [Faint text]		17. SIGNATURE OF REGISTRAR [Faint text]		18. SIGNATURE OF WITNESS [Faint text]		19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF NEXT OF KIN [Faint text]	

BUREAU V. 1

DEC 19 1957

RECEIVED

127632 CERTIFICATE OF DEATH

1276328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 PARKVILLE</u>			
c. LENGTH OF STAY IN 1b <u>LIFE</u>				d. STREET ADDRESS <u>8623 WENDELL AVE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8623 WENDELL AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROY</u> First <u>FOUND</u> Middle <u>FOUND</u> Last				4. DATE OF DEATH <u>Dec</u> Month <u>26</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 13 1894</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER - News Post</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>219-01-4568</u>		17. INFORMANT <u>MYRTLE FOUND</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum with metastases</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 20, 1955</u> to <u>Dec. 26, 1957</u> , that I last saw the deceased alive on <u>Dec 26, 1957</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>6217 Harford Rd Baltimore - 14 Md</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Dec 30 - 1957</u>		<u>MORELAND MEMORIAL</u>		<u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F EVANS + SON</u>				ADDRESS <u>8802 HARFORD RD</u>		24a. REC'D BY REGISTRAR <u>DEC 30 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED					
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER					
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		BUSINESS		OTHER					
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER							
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		OTHER					
MARITAL STATUS		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED					
DATE OF DEATH															
PLACE OF DEATH		HOME		HOSPITAL		NURSING HOME		OTHER							
SIGNATURE OF DECEASED															
SIGNATURE OF WITNESS															
SIGNATURE OF PHYSICIAN															
SIGNATURE OF CORONER															
SIGNATURE OF JURY															
SIGNATURE OF JUDGE															

BUREAU V. 1

DEC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12783 CERTIFICATE OF DEATH

12764 33

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ABERDEEN 12X1.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 ROSEWOOD STATE TRAINING SCHOOL		d. STREET ADDRESS Box 41	
3. NAME OF DECEASED (Type or print) First LUCINDA Middle TRENE Last FRANKO		4. DATE OF DEATH Month DECEMBER Day 31 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 26, 1924 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME STEPHEN FRANKO		14. MOTHER'S MAIDEN NAME ALICE M. WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT ROSEWOOD RECORDS Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSSIBLE CARDIAC FAILURE 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SECONDARY ANEMIA DUE TO (c) MONGOLISM		INTERVAL BETWEEN ONSET AND DEATH 5 minutes Unknown Birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from 31 Dec , 1957, to 31 Dec , 1957, that I last saw the deceased alive on 31 Dec , 1957, and that death occurred at 5 P M, from the causes and on the date stated above.		
ACTUAL SIGNATURE Harry B. Butler M.D.		DATE SIGNED Clowings Mills, Md 12/31/57
PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
Burial	11/3/57	Angel Hill
23. FUNERAL DIRECTOR'S SIGNATURE		22d. LOCATION (City, town, or county) (State)
Clowings Mills, Md		Harford County, Md
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
12/31/57		Mary E. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 3 1959

RECEIVED

12784 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. NAME OF DECEASED (Type or Print) ABBIE H. FRENCH			2. DATE OF DEATH Dec. 19, 1957		
3. PLACE OF DEATH: A. Residence Maryland TOWSON			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Baltimore		
B. FULL NAME OF deceased hospital or institution, give street address or location Baltimore County 407 Donegal Drive			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 407 Donegal Drive		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH June 15, 1865	9. AGE (In years last birthday) 92	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) New Hampshire
13. FATHER'S NAME Edward Luther Hall			12. CITIZEN OF WHAT COUNTRY? Helen Marr Walker		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mrs. Helen M. Hall - 407 Donegal Drive
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema DUE TO Arteriosclerotic cardio-vascular disease DUE TO Parasitic disease			INTERVAL BETWEEN ONSET AND DEATH 7 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 19, 1957 to Dec 17, 1957 , that (I) (we) last saw the deceased alive on Dec 17, 1957 , and that death occurred at 10:05 p.m. from the causes and on the date stated above.					
23A. SIGNATURE Charles M. Kern ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS 6801 Belair Rd.		23C. DATE SIGNED Dec 20, 57.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 12/20/57	24C. NAME OF CEMETERY OR CREMATORY Mt. View Cem.		24D. LOCATION (City, town, or county) (State) Claremont, N.H.
DATE RECEIVED BY LOCAL REGISTRAR Dec. 24, 1957		REGISTRAR'S SIGNATURE Malik Gray		25. FUNERAL DIRECTOR ADDRESS Wm. L. Vickner Sons - Balt. 17	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED

DEC 27 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12785

CERTIFICATE OF DEATH

12766

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>12yr10mths2dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Blumenthal</u> Last <u>Friedman</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December, 1876</u>	9. AGE (In years last birthday) <u>81?</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>	
13. FATHER'S NAME <u>Abraham Siegel</u>				14. MOTHER'S MAIDEN NAME <u>Naomi ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>Sept. 25, 1957</u> , to <u>Dec. 13, 1957</u> , that I last saw the deceased alive on <u>Dec. 13, 1957</u> , and that death occurred at <u>6:45a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachsler</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 12-13-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>Dec 13/57</u>	<u>Ohel Shalom</u>		<u>Baltimore, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Gerinson & Puts</u>				ADDRESS <u>2nc -1124-26 W. North</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>			

BUREAU V. S.

DEC 16 1957

RECEIVED

1

12786

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

127674

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland		c. LENGTH OF STAY IN 1b 67 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Old Court Road	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle M. Last FULLER		4. DATE OF DEATH Month December Day 31 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1894
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	
11. BIRTHPLACE (State or foreign country) Lauraville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Fuller		14. MOTHER'S MAIDEN NAME Ida Barton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 222-01-5104	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from October 25, 1957 to December 31, 1957 , and that death occurred at 4:57 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE George Vash M.D. VAH, Fort Howard, Md. 12/31/57		
PHYSICIAN'S NAME (Type) GEORGE VASH, M. D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 3, 1958	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Md.	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		24a. REC'D BY REGISTRAR 1/4/58	24b. REGISTRAR'S SIGNATURE Danson L. Sharkey

5005 Pk Hydrant
Balt 15, Md.

CERTIFICATE OF DEATH

1958

For State Use

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. RACE [REDACTED]</p>	
<p>7. OCCUPATION [REDACTED]</p>		<p>8. MARITAL STATUS [REDACTED]</p>		<p>9. EDUCATION [REDACTED]</p>	
<p>10. DATE OF DEATH [REDACTED]</p>		<p>11. TIME OF DEATH [REDACTED]</p>		<p>12. PLACE OF DEATH [REDACTED]</p>	
<p>13. CAUSE OF DEATH [REDACTED]</p>		<p>14. MANNER OF DEATH [REDACTED]</p>		<p>15. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>16. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF DECEASED [REDACTED]</p>	

BUREAU V. S.

JAN 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12787 CERTIFICATE OF DEATH

12768/1
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1607 Potomac Avenue</u>				d. STREET ADDRESS <u>1607 Potomac avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leslie</u> <u>Boyd</u> <u>Fuller</u>				4. DATE OF DEATH Month Day Year <u>December</u> <u>9th</u> <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25th 1894</u>		9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glass Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Glass Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Winchester Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Fuller</u>				14. MOTHER'S MAIDEN NAME <u>Emma Yew</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW1</u>		16. SOCIAL SECURITY NO. <u>216-05-7215</u>		17. INFORMANT Address <u>Mollie Fuller 1607 Potomac Avenue 27</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema and</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peptic Ulcers Active</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/3/57</u> , 19 <u>57</u> , to <u>12/9/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/9/57</u> , 19 <u>57</u> , and that death occurred at <u>1:40</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Frederick</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1305 Francis Ave. 12/9/57</u>			
PHYSICIAN'S NAME (Type) <u>J. N. Frederick</u>				<u>1305 Francis Avenue</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Webb Jr.</u>				ADDRESS <u>705 S. Ann St.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 10 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. DATE OF DEATH [Faint text]		5. TIME OF DEATH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]		9. SIGNATURE OF PHYSICIAN [Faint text]	
10. SIGNATURE OF REGISTRAR [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12718 CERTIFICATE OF DEATH

Reg. Dist. No.

12789

1. PLACE OF DEATH a. COUNTY Dundalk MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 702I 5th Ave		d. STREET ADDRESS 702I 5th Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Peter Middle Paul Last Gabriel		4. DATE OF DEATH Month 12 - Day 13 Year 19 57	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bethl, Steel Co	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Gabriel		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Agnes Gabriel		Address 702I 5th Ave Dundalk	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1957 , to 12/13 , 1957, that I last saw the deceased alive on 12/13 , 1957, and that death occurred at 8:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3508 BANK ST BALTO MD DATE SIGNED 12/14/57			
ACTUAL SIGNATURE Joseph R. Liberto M.D.		PHYSICIAN'S NAME (Type) JOSEPH R - LIBERTO, Baltimore 24, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-57	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Balto Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Gabrowski ADDRESS 1001 Dundalk Ave.		24a. REC'D BY REGISTRAR DEC 18 1957 24b. REGISTRAR'S SIGNATURE Wm. Kelly	

12788 CERTIFICATE OF DEATH

12770

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6719 Broadview Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George M. Gambrill				4. DATE OF DEATH 12 Month 6 Day 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steamfitter				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME George Gambrill				14. MOTHER'S MAIDEN NAME Mary Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-10-0161		17. INFORMANT Address Calvin Gambrill 6719 Broadview Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia - Bronchial 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Hypertensive Cardio Vascular disease DUE TO (c) 6 yrs.							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec 5 , 19 51 , to Dec 6 , 19 57 , that I last saw the deceased alive on Dec 5 , 19 57 , and that death occurred at 11:45 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold H. Burns M.D.				ADDRESS (Street, city or town, state) 115 E. Oger St. Wash, D.C.			
PHYSICIAN'S NAME (Type) Harold H. Burns				DATE SIGNED Dec 5, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9-57		22c. NAME OF CEMETERY OR CREMATORY Butler Church Methodist Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold H. Burns				ADDRESS 814 W 36th St.		24a. REC'D BY REGISTRAR DEC 10 1957	
				24b. REGISTRAR'S SIGNATURE Anthony Newell			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3801-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1099 West Fayette Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia Middle E. Last Gilbert				4. DATE OF DEATH Month December Day 12 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1875 1875		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown David Clark				14. MOTHER'S MAIDEN NAME Mary unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.9 Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Vascular Disease DUE TO (c) fracture right femur							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Accidental							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Had been patient at Hunt Hosp, brought her 6 days ago					
20c. TIME OF INJURY Month, Day, Year Hour a. m. Jan 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-57		22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE DEC 17 '57		24b. REGISTRAR'S SIGNATURE W. H. Smith	

ALABAMA STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

DEC 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12790 CERTIFICATE OF DEATH

12772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1718 Yakona Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jane Middle Edna Last Glunt		4. DATE OF DEATH Month Dec. Day 20, Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1882
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY McVetown, Pa.	
11. BIRTHPLACE (State or foreign country) McVetown, Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles E. Hineksbaugh		14. MOTHER'S MAIDEN NAME Elizabeth Rank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ethel G. Childs		Address 6305 Charles St. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15 , 19 57 , to 12/20 , 19 57 , that I last saw the deceased alive on 12/20 , 19 57 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon Grau		ADDRESS (Street, city or town, state) DATE SIGNED 8523 Loch Raven Blvd. 12/21/57	
PHYSICIAN'S NAME (Type) Gordon Grau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 23, 1957	22c. NAME OF CEMETERY OR CREMATORY Mooreland Memorial Park	22d. LOCATION (City, town, or county) (State) Taylor Ave. Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Pl.	
24a. REC'D BY REGISTRAR DEC 23 1957		24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacon	

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12791

CERTIFICATE OF DEATH

127734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 1107 Carson Ct.,			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle GOINS Last GOINS				4. DATE OF DEATH Month December Day 29 Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/88	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cement Company		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Goins				14. MOTHER'S MAIDEN NAME Betty West			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 216-18-3864		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF RIGHT BRONCHUS WITH 162x METASTASIS TO MEDIASTINAL LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore, Maryland	(County)	(State)	
21. I certify that VA attended the deceased from November 23, 19 57 to December 29, 19 57 and that death occurred at 12:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Fort Howard, Maryland DATE SIGNED 12/30/57 ACTUAL SIGNATURE Chien Wei Lan M.D. Chien Wei Lan, M.D. PHYSICIAN'S NAME (Type) CHIENT WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-3-58	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. Kelson, Jr. ADDRESS 1303 Presstman St., Balto. 17, Md.				24a. REC'D BY REGISTRAR 12/31/57		24b. REGISTRAR'S SIGNATURE Barber	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		1922-10-15	
Place of Birth		Race		Occupation		Cause of Death	
Baltimore, Md		White		Teacher		Heart Disease	
Date of Death		Place of Death		Manner of Death		Certified by	
1957-12-01		Home		Natural		Dr. J. Smith	
Signature of Registrar		Signature of Physician		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	

DEC 31 1957

RECEIVED

BUREAU V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 18 Film 223 12-23-57 ams											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
12792 1277437											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2807 Laurel Wood Court						d. STREET ADDRESS 2807 Laurel Wood Court					
3. NAME OF DECEASED (Type or print) First JAMIE Middle SUE Last GOODMAN						4. DATE OF DEATH Month December Day 1 Year 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1957		9. AGE (In years last birthday) yrs. 5 mos. 7 days		IF UNDER 1 YEAR Months 5 Days 7 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William L. Goodman						14. MOTHER'S MAIDEN NAME Alice Katzenstein					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO.		17. INFORMANT William L. Goodman - Jane					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia complicated by Aspiration of Vomitus 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) None										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Paul F. Guerin						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12/2/57		
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/57		22c. NAME OF CEMETERY OR CREMATORY Chapel Amigo				22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Burdette						ADDRESS 124-26 W. North		24a. REC'D BY REGISTRAR DEC 3 1957		24b. REGISTRAR'S SIGNATURE Dorothy Newell	

2033222 XV4

RECEIVED

DEC 3 1957

BUREAU V. S.

Paul H. Jones

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

: 12793

CERTIFICATE OF DEATH

12775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 89 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 5805 Key Ave.			
3. NAME OF DECEASED (Type or print) First Louis Middle NMI Last GOTTESMAN				4. DATE OF DEATH Month December Day 21 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 21, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scranton, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ignatz Gottesman				14. MOTHER'S MAIDEN NAME Sarah Simonowitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 216-03-8603		17. INFORMANT Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 193X IMMEDIATE CAUSE (a) ASTROCYTOMA, BRAIN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 Months							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that VA attended the deceased from Sept. 23 , 19 57 , to Dec. 21 , 19 57 , and that death occurred at 11:15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Fort Howard, Maryland DATE SIGNED 12/21/57							
ACTUAL SIGNATURE Silverio Q. Arce M.D.				PHYSICIAN'S NAME (Type) Silverio Q. ARCE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/22/57		22c. NAME OF CEMETERY OR CREMATORY Keshre-Zion		22d. LOCATION (City, town, or county) (State) Reading, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson				24a. REC'D BY REGISTRAR Q. L. Farber		24b. REGISTRAR'S SIGNATURE Q. L. Farber	

Sol Levinson 1126 W. North Ave., Balte., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 104

BUREAU V. 81

DEC 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

12794

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12776

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND LINE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 BALTIMORE 21</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8545 PULASKI HIGHWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA ELIZABETH GOWLAND</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YORK, PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>YORK, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>JOHN B. LARTZ</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Dorothy R. Myers</u>		Address <u>340 W. North St. YORK, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury of chest</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>11/22 12/22 1957</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT. 111</u>	20f. (City or town) (County) (State) <u>Md Line BALTO. Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. M. France</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/22/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>York, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOK-TOWSON-GIVING-TOWSON-MD</u>		24b. REGISTRAR'S SIGNATURE <u>Chester L. Fulton</u>	
24a. REC'D BY REGISTRAR <u>DATE 12/26/57</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH DEPT
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME - DEATH	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
SEX	
AGE	
RACE	
EDUCATION	
OCCUPATION	
RELIGION	
MARRIAGE	
CHILDREN	
SIBLINGS	
PARENTS	
GRANDPARENTS	
BROTHERS	
SISTERS	
Nephews	
Nieces	
Aunts	
Uncles	
Cousins	
In-laws	
Other relatives	
Friends	
Neighbors	
Community	
Other	
Remarks	
Signature of Medical Examiner	
Date of Signature	
Place of Signature	
Official Seal	
Filing Stamp	
Distribution Stamp	
Archival Stamp	
Indexing Stamp	
Classification Stamp	
Status Stamp	
Completion Stamp	
Final Stamp	

BUREAU V. S.

DEC 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12777

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b 6 mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 409 Edgewater Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RAYMOND HOWARD GRAHAM		4. DATE OF DEATH December 17, 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BOBBY J. GRAHAM		14. MOTHER'S MAIDEN NAME MARTHA H. G. HUDAK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT B. J. GRAHAM		Address - SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DATE SIGNED 12/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/20/57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Bald. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Headland, Md.		24a. REC'D BY REGISTRAR DEC 18 1957	
ADDRESS 2033 213 XV3		24b. REGISTRAR'S SIGNATURE Edith Turley	

1
HEALTH DEPT
NOT STATE

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

REC 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

12796

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO INVERNESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 846 OAKLEIGH BEACH AVE.				d. STREET ADDRESS 846 OAKLEIGH BEACH AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELEANORA F. GRANVILLE				4. DATE OF DEATH 12/11/1957		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH NOV. 14 1904				9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MIXER = Poplar				10b. KIND OF BUSINESS OR INDUSTRY CLUB BEV. Co. = BALTO - MD.				11. BIRTHPLACE (State or foreign country)			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Geo. C. Jr. 846 OAKLEIGH BEACH Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE M.B. Davis MD				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis MD				DATE SIGNED 12/13/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				22b. DATE THEREOF 12/14/57		22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMT.		22d. LOCATION (City, town, or county) (State) BALTO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE E. F. Hoffmann				ADDRESS 3218 Hudson St.		24a. REC'D BY REGISTRAR DEC 17 1957		24b. REGISTRAR'S SIGNATURE Edith H. H. H.			

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOURS	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
FINDINGS AT AUTOPSY		OPINION OF EXAMINER		SIGNATURE OF EXAMINER		DATE		PLACE	

BUREAU V. 3

DEC 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

12797 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 12 FilmG223 12-9-57 et
12779
CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrison, Maryland		d. STREET ADDRESS Surmont	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SIDNEY Middle GREENBAUM Last		4. DATE OF DEATH Month 12 Day 2 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1887
9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Greenbaum		14. MOTHER'S MAIDEN NAME Frances ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-07-0255	
17. INFORMANT Mr. Daniel S. Greenbaum-Garrison, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases to bladder DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of rectum DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/8 , 19 57 , to 12/2 , 19 57 , that I last saw the deceased alive on Nov. 27, 1957 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Jonas Cohen M.D.			
PHYSICIAN'S NAME (Type) Dr. Jonas H. Cohen			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/3/57	
22c. NAME OF CEMETERY OR CREMATORY Balto. Hebrew Congre. Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckner & Sons		24a. REC'D BY REGISTRAR 12/3/57	
24b. REGISTRAR'S SIGNATURE Dorothy Mervell			

RECEIVED

12798 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea Rural</u>				c. LENGTH OF STAY IN lb <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7415 Kenlea Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Karl Konrad Hacke</u>				4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1904</u>	9. AGE (In years last birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Motors</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Hacke</u>			
14. MOTHER'S MAIDEN NAME <u>Kunigunda Hopfengartner</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>212-01-3369</u>				17. INFORMANT Address <u>Mrs. Dorothy E. Hacke 7415 Kenlea Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>rectum ca</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 14</u> , 19 <u>57</u> , to <u>Dec 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>57</u> , and that death occurred at <u>SP</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>1 W. OVERLEA AVE</u>				DATE SIGNED <u>12/17/57</u>			
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>DR. R. R. M. BALTO, 6 MD</u>			
PHYSICIAN'S NAME (Type) <u>DR. R. R. M. BALTO, 6 MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				DATE <u>19 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12799

CERTIFICATE OF DEATH

Reg. Dist. No.

12781/4

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Baltimore</u> x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1050 Old North Point Road</u>		d. STREET ADDRESS <u>1050 Old North Point Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>EDWIN</u> Middle <u>HACKETT</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>10</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 20, 1914</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin M. Hackett</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Hilmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1050 Old North Point Road</u>	
17. INFORMANT <u>Mrs. Margaret Hackett</u>		Address <u>1050 Old North Point Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Glomerular Nephritis</u> DUE TO (c) <u>HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>42</u> , to <u>Dec 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>57</u> , and that death occurred at <u>3:20 p. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris A. Jacobs</u>		ADDRESS (Street, city or town, state) <u>1010 NORTH Point Rd Baltimore 24 Md</u>	
PHYSICIAN'S NAME (Type) <u>MORRIS A. Jacobs</u>		DATE SIGNED <u>12/11/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road,</u>		24a. REC'D BY REGISTRAR <u>DEC 13 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Sawmorth Bailey</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

DEC 13 1957

RECEIVED

12800

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				d. STREET ADDRESS 14 Dutton Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Ennis Hall				4. DATE OF DEATH Month Day Year Dec. 23 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1880		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William B. Ennis				14. MOTHER'S MAIDEN NAME Emma Shirley LETSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address Mrs. Henry H. Helfrich 4 Dutton Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Jaw DUE TO (c) Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 2 mos - 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension 491X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1928 , to Dec 23 1957 , that I last saw the deceased alive on Dec 23 1957 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wetherbee Fort				ADDRESS (Street, city or town, state) DATE SIGNED 1118 St. Paul St - Balto. 2			
PHYSICIAN'S NAME (Type) Wetherbee Fort				ADDRESS 1118 St. Paul St -			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57		22c. NAME OF CEMETERY OR CREMATORY Western Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md.				24a. REC'D BY REGISTRAR DATE DEC 30 '57		24b. REGISTRAR'S SIGNATURE Alfred	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BOREAU V. S.

DEC 30 1957

RECEIVED

1 **FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12783

12801 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - MILLERS</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO RURAL - MILLERS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>LESLIE</u> Middle <u>HARRIS</u> Last			4. DATE OF DEATH <u>Dec 4</u> Month <u>1957</u> Day Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 3, 1903</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chaffer-ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William Harris</u>		
14. MOTHER'S MAIDEN NAME <u>Florence Schaefer</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Mrs. Chas. L. Harris - Millers, Md.</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>A. M. France</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	
22d. LOCATION (City, town, or county) <u>Towson, Md.</u>		22e. (State) <u>Md.</u>		22f. (County) <u>Towson</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons - Towson, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>DEC 9 '57</u>		
			24b. REGISTRAR'S SIGNATURE <u>Reverend</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 9 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

RECEIVED
BALTIMORE
DEC 10 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12802 CERTIFICATE OF DEATH

1278438
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1515 Joppa Road</u>		d. STREET ADDRESS <u>1515 Joppa Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Alexander Taylor Harrison</u>		4. DATE OF DEATH Month Day Year <u>Dec. 16, 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Hotel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mgr</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Tudor Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte F. Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>D. Heyward Hamilton, Jr. Ruxton 4, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.1 OESOPHAGEAL HEMMORRHAGE 2-3 WEEKS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ALCOHOLIC CIRRHOSIS OF LIVER 1 YEAR</u> DUE TO (c) <u>WITH ASCITES AND MALNUTRITION 10 MONTHS</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Balto, Md.</u>		(County) (State)
21. I certify that I attended the deceased from <u>DEC 16, 1956</u> , to <u>DEC 16, 1957</u> , that I last saw the deceased alive on <u>DEC 16, 1957</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Ralph G. Hills</u>		DATE SIGNED <u>18 E. EAGER ST. BALTO. 2 MARYLAND</u>
PHYSICIAN'S NAME (Type) <u>Dr. Ralph G. Hills</u>		<u>18 E. Eager St. Baltimore 2, Md. Dec 17 57</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>DEC 18 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>
22d. LOCATION (City, town, or county) <u>Balto, Md.</u>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jenkins 4905 York Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 1957</u>
24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		

BUREAU V. S.

DEC 19 1957

RECEIVED

12803

CERTIFICATE OF DEATH

12785 32
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE WEST OCEAN CITY b. COUNTY WIC: MD.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST OCEAN CITY RT. #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 23 X 2.2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HASTINGS, HARRY WILLIAM				4. DATE OF DEATH Month 12 Day 1 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/10	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 10 Days 15	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISHERMAN		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME HASTINGS, LAMBERT				14. MOTHER'S MAIDEN NAME SARA FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW II ARMY		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG 169X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour — a. m. 19 p. m.	Month —	Day —	Year —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 11/26 , 19 57 , to 12/1/57 , that I last saw the deceased alive on 11/30 , 19 57 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED —							
ACTUAL SIGNATURE William Newcomer				M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/3/57		EVERGREEN		Berlin Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dwight A. Bullock				ADDRESS Berlin Md		24. RECEIVED BY REGISTRAR DATE DEC 4 1957	
				25. REGISTRAR'S SIGNATURE Dorothy Newell			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12719

Item 1 Film G223 12-30-57 et
Item 6 Film G224 1-3-58 et

CERTIFICATE OF DEATH

12786 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		d. STREET ADDRESS <u>1901 Walnut Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Havlicek</u> Last <u>Donnell</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 1888</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Don't Know</u>		14. MOTHER'S MAIDEN NAME <u>Don't Know</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Vincent Havlicek 6432 O'Donnell</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 men</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20</u> , 19 <u>57</u> , to <u>12-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-16</u> , 19 <u>57</u> , and that death occurred at <u>12:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack C Collins</u>		ADDRESS (Street, city or town, state) <u>BALT 22 Md</u>	
PHYSICIAN'S NAME (Type) <u>JACK C COLLINS</u>		DATE SIGNED <u>24 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Dec 24 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Stanislaus</u>		22d. LOCATION (City, town, or county) (State) <u>Dundalk Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home</u>		ADDRESS <u>Dundalk Md</u>	
24a. REC'D BY REGISTRAR <u>24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Kelly</u>	

CERTIFICATE OF DEATH

1-1-1957

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>1912</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>LABORER</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. DATE OF MARRIAGE <i>1935</i>	
9. PLACE OF DEATH <i>HOME</i>		10. CAUSE OF DEATH <i>HEART DISEASE</i>	
11. TIME OF DEATH <i>10:30 PM</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF REGISTRAR <i>[Signature]</i>		14. DATE OF REGISTRATION <i>DEC 24 1957</i>	

RECEIVED
DEC 24 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12720 CERTIFICATE OF DEATH

Reg. Dist. No.

12787

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 18 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2903 Dunglow Road		d. STREET ADDRESS 2903 Dunglow Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES MATTHEW HELMAN, Sr.		4. DATE OF DEATH Month Day Year December 5th, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 4, 1903
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Eng.		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John Helman		14. MOTHER'S MAIDEN NAME Agnes Blough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 190-05-4498	
17. INFORMANT Elizabeth L. Helman		Address as in #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Sigmoid Colon DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 mos. 1-2 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1 , 19 57 , to Dec. 5 , 19 57 , that I last saw the deceased alive on Dec. 5 , 19 57 , and that death occurred at 6:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James T. Means M.D. 12/7/57			
ACTUAL SIGNATURE James T. Means M.D. PHYSICIAN'S NAME (Type) James T. Means, M.D., 4th & D Sts, Sparrows Point 19, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Bradley		ADDRESS Dundalk 22, Md.	
24a. REC'D BY REGISTRAR DEC 9 1957		24b. REGISTRAR'S SIGNATURE Mr. Kelly	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>11. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>12. DATE OF DEATH [REDACTED]</p>	
<p>13. PLACE OF DEATH [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF DECEASED [REDACTED]</p>		<p>16. SIGNATURE OF NEXT OF KIN [REDACTED]</p>	
<p>17. SIGNATURE OF BURIAL OFFICIAL [REDACTED]</p>		<p>18. SIGNATURE OF CHURCH OFFICIAL [REDACTED]</p>	
<p>19. SIGNATURE OF FUNERAL HOME [REDACTED]</p>		<p>20. SIGNATURE OF CEMETERY [REDACTED]</p>	
<p>21. SIGNATURE OF HEALTH OFFICIAL [REDACTED]</p>		<p>22. SIGNATURE OF COUNTY CLERK [REDACTED]</p>	
<p>23. SIGNATURE OF STATE DEPARTMENT OF HEALTH [REDACTED]</p>		<p>24. SIGNATURE OF BALTIMORE CITY CLERK [REDACTED]</p>	

RECEIVED
DEC 9 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12804 CERTIFICATE OF DEATH

12788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>5yr6mth10dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <u>3V01-4</u>			
5. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle Last <u>Hepperla</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>4</u> Year <u>1957</u>			
6. SEX <u>female</u>		7. COLOR OR RACE <u>white</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>Dec. 5, 1871</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Hepperla</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise Coale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS. +</u> " " "							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Oct. 18</u> , 19 <u>57</u> , to <u>DEC. 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>DEC. 3</u> , 19 <u>57</u> , and that death occurred at <u>2:43A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Jonas R. Rapoport</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> PHYSICIAN'S NAME (Type) <u>Jonas R. Rapoport M.D.</u> <u>Catonsville 28, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thm. J. Sicker & Sons - Balto Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 5 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Dee Leach</u>	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12805 CERTIFICATE OF DEATH

Reg. Dist. No. 12789 45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7009 Dunbar Road				d. STREET ADDRESS 7009 Dunbar Road #22			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle EDWARD Last Hertje				4. DATE OF DEATH Month 12 Day 1 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1860		9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months 1 Days 1 Hours 19 Min.	IF UNDER 24 HRS. Months 1 Days 1 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pomeroy, Ohio	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Valentine Hertje				14. MOTHER'S MAIDEN NAME Barbara Huff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ida Clark-7009 Dunbar Road-Balto. 22, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease DUE TO Generalized Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arterio Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Feb Jan , 19 55 , to 12-1 , 19 57 , that I last saw the deceased alive on 12-1 , 19 57 , and that death occurred at 10:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack C Collins				ADDRESS (Street, city or town, state) 2 Kinship		DATE SIGNED 12-1-57	
PHYSICIAN'S NAME (Type) JACK C COLLINS				BALTO 22			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/4/57		22c. NAME OF CEMETERY OR CREMATORY Hertje Cemetery		22d. LOCATION (City, town, or county) (State) Jackson County, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons				ADDRESS Wm. J. Tucker & Sons		24a. REC'D BY REGISTRAR Edith Hurley	
DATE 12/3/57				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. HOME		2. DATE OF DEATH	
b. HOSPITAL		3. TIME OF DEATH	
c. OTHER		4. PLACE OF BURIAL	
5. NAME OF DECEASED		6. SEX	
7. AGE		8. RACE	
9. OCCUPATION		10. MARITAL STATUS	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
15. DATE		16. TIME	

BUREAU V. 2

JEC 4 1957

RECEIVED

12806 CERTIFICATE OF DEATH

12790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Osburn Road</u>		d. STREET ADDRESS <u>2017 E. 32nd St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace R. Hildreth</u>		4. DATE OF DEATH Month Day Year <u>12/26/57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/17/1922</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LIQUOR BOARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE</u>	9. AGE (In years last birthday) <u>35</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Hildreth</u>		14. MOTHER'S MAIDEN NAME <u>M. Cornelia Hildreth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Clarence Hildreth</u>		Address <u>2017 E. 32nd. St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> (c) <u>Hypertension, Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Gradual</u> <u>"</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>40</u> , to <u>Dec 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 24</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Hoody</u>		ADDRESS (Street, city or town, state) <u>1403 Park Ave Baltimore 17 md</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Hoody</u>		DATE SIGNED <u>12-26-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE 12 2 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hoody</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 15

REG. NO. 104

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 2 1903	
AGE		SEX	
65		M	
PLACE OF BIRTH		OCCUPATION	
BALTIMORE, MD.		CLOCK REPAIRER	
MARITAL STATUS		CAUSE OF DEATH	
MARRIED		HEART DISEASE	
DATE OF MARRIAGE		PLACE OF DEATH	
JAN 1 1903		BALTIMORE, MD.	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

JAN 2 1903

RECEIVED

12807

CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>W.</u> Last <u>Hilker</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1864</u>	9. AGE (In years, months, days) <u>93</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Hilker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Zimmerman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Cara Hilker, Freeland Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO <u>unknown</u> (c) <u>unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>marked obesity</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cerebral thrombus - no injury</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
				20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>			
21. I certify that I attended the deceased from <u>9-4-</u> , 19 <u>55</u> , to <u>12-19-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-19-57</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Robinson</u>				ADDRESS (Street, city or town, state) <u>New Freedom, Pa.</u>			
PHYSICIAN'S NAME (Type) <u>R. ROBINSON</u>				DATE SIGNED <u>12-23-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Steltz Cemetery</u>		22d. LOCATION (City, town, or county) <u>Glen Rock, Pa.</u> (State) <u>R.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nicol Hartenstein</u>				24. REGISTRAR'S SIGNATURE <u>Chester L. Sultany</u>			
ADDRESS <u>New Freedom, Pa.</u>				DATE <u>12-23-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 24 1957

BUREAU V. 8

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES EARL RAY	
2. SEX Male	
3. AGE 35	
4. DATE OF DEATH June 4, 1957	
5. PLACE OF DEATH Baltimore, Maryland	
6. CAUSE OF DEATH Suicide by gunshot wound of the chest	
7. MANNER OF DEATH Suicide	
8. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
9. SIGNATURE OF CORONER J. Edgar Hoover	
10. SIGNATURE OF DEATH REGISTRAR J. Edgar Hoover	
11. SIGNATURE OF WITNESS J. Edgar Hoover	
12. SIGNATURE OF DECEASED J. Edgar Hoover	
13. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
14. SIGNATURE OF BURIAL OFFICIAL J. Edgar Hoover	
15. SIGNATURE OF FUNERAL HOME J. Edgar Hoover	
16. SIGNATURE OF CEMETERY J. Edgar Hoover	
17. SIGNATURE OF CHURCH J. Edgar Hoover	
18. SIGNATURE OF OTHER J. Edgar Hoover	

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12792

12808

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1807 E. Joppa Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. John M. Hilliard Sr.</u>				4. DATE OF DEATH <u>December 11th 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1898</u>	9. AGE (In years last birthday) <u>59 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John M. Hilliard</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-10-7292</u>		17. INFORMANT <u>Mrs. Anna Marie Hilliard,</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epidermoid Carcinoma</u> (c) <u>probably lung</u>						INTERVAL BETWEEN ONSET AND DEATH <u>March 1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. n. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>December 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 11</u> , 19 <u>57</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William L. Garlick</u> M.D.				ADDRESS (Street, city or town, state) <u>700 N. Charles St.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>William L. Garlick, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>DEC 17 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Nobel Gray</u>	

RECEIVED

DEC 17 1957

BUREAU V. S.

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. TIME OF DEATH	
5. SEX		6. AGE	
7. RACE		8. OCCUPATION	
9. MARITAL STATUS		10. EDUCATION	
11. RELIGION		12. CAUSE OF DEATH	
13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN	
15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT	
21. SIGNATURE OF BURIAL		22. SIGNATURE OF INTERMENT	
23. SIGNATURE OF BURIAL		24. SIGNATURE OF INTERMENT	
25. SIGNATURE OF BURIAL		26. SIGNATURE OF INTERMENT	
27. SIGNATURE OF BURIAL		28. SIGNATURE OF INTERMENT	
29. SIGNATURE OF BURIAL		30. SIGNATURE OF INTERMENT	
31. SIGNATURE OF BURIAL		32. SIGNATURE OF INTERMENT	
33. SIGNATURE OF BURIAL		34. SIGNATURE OF INTERMENT	
35. SIGNATURE OF BURIAL		36. SIGNATURE OF INTERMENT	
37. SIGNATURE OF BURIAL		38. SIGNATURE OF INTERMENT	
39. SIGNATURE OF BURIAL		40. SIGNATURE OF INTERMENT	
41. SIGNATURE OF BURIAL		42. SIGNATURE OF INTERMENT	
43. SIGNATURE OF BURIAL		44. SIGNATURE OF INTERMENT	
45. SIGNATURE OF BURIAL		46. SIGNATURE OF INTERMENT	
47. SIGNATURE OF BURIAL		48. SIGNATURE OF INTERMENT	
49. SIGNATURE OF BURIAL		50. SIGNATURE OF INTERMENT	
51. SIGNATURE OF BURIAL		52. SIGNATURE OF INTERMENT	
53. SIGNATURE OF BURIAL		54. SIGNATURE OF INTERMENT	
55. SIGNATURE OF BURIAL		56. SIGNATURE OF INTERMENT	
57. SIGNATURE OF BURIAL		58. SIGNATURE OF INTERMENT	
59. SIGNATURE OF BURIAL		60. SIGNATURE OF INTERMENT	
61. SIGNATURE OF BURIAL		62. SIGNATURE OF INTERMENT	
63. SIGNATURE OF BURIAL		64. SIGNATURE OF INTERMENT	
65. SIGNATURE OF BURIAL		66. SIGNATURE OF INTERMENT	
67. SIGNATURE OF BURIAL		68. SIGNATURE OF INTERMENT	
69. SIGNATURE OF BURIAL		70. SIGNATURE OF INTERMENT	
71. SIGNATURE OF BURIAL		72. SIGNATURE OF INTERMENT	
73. SIGNATURE OF BURIAL		74. SIGNATURE OF INTERMENT	
75. SIGNATURE OF BURIAL		76. SIGNATURE OF INTERMENT	
77. SIGNATURE OF BURIAL		78. SIGNATURE OF INTERMENT	
79. SIGNATURE OF BURIAL		80. SIGNATURE OF INTERMENT	
81. SIGNATURE OF BURIAL		82. SIGNATURE OF INTERMENT	
83. SIGNATURE OF BURIAL		84. SIGNATURE OF INTERMENT	
85. SIGNATURE OF BURIAL		86. SIGNATURE OF INTERMENT	
87. SIGNATURE OF BURIAL		88. SIGNATURE OF INTERMENT	
89. SIGNATURE OF BURIAL		90. SIGNATURE OF INTERMENT	
91. SIGNATURE OF BURIAL		92. SIGNATURE OF INTERMENT	
93. SIGNATURE OF BURIAL		94. SIGNATURE OF INTERMENT	
95. SIGNATURE OF BURIAL		96. SIGNATURE OF INTERMENT	
97. SIGNATURE OF BURIAL		98. SIGNATURE OF INTERMENT	
99. SIGNATURE OF BURIAL		100. SIGNATURE OF INTERMENT	

12809 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>8mth16dys</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Sparrows, Point, Md.</u>				d. STREET ADDRESS <u>432 "F" Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sebastian</u> Middle <u>Hock</u> Last <u>Hock</u>				4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1882</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>75</u> Days <u>17</u> Hours <u>19</u> Min. <u>57</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Hock</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Schindhelm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> <u>605X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured bladder</u> DUE TO (c) <u>Acute urinary retention and cystitis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 20, 1957</u> , to <u>Dec. 17, 1957</u> , that I last saw the deceased alive on <u>Dec. 17, 1957</u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u>				DATE SIGNED <u>12-18-57</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				<u>Catonsville 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7401 GERMAN HILL RD., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Geiler</u>				ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

DEC 23 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12810

CERTIFICATE OF DEATH

1279431

Reg. Dist. No. 7H

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holbrook</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Mariottville P.O. Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Va</u> Last <u>Horn</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 3, 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Jesse Dell</u>				14. MOTHER'S MAIDEN NAME <u>Susanna Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Foster Parker, Mariottville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Cardiac failure,</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis, hypertension, left heart failure,</u> DUE TO (c) <u>Carcinoma of breast i metastasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1956</u> <u>+0</u> <u>Dec 1957</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug</u> 19 <u>57</u> , to <u>Dec 11, 1957</u> , that I last saw the deceased alive on <u>10 Dec</u> 19 <u>57</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Shelville, Md</u> DATE SIGNED <u>11 Dec 57</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				BY <u>Kesville, MD,</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ward's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Holbrook, Balt Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Shelville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-13-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Jm. Martins</u>	

BUREAU V. S.

DEC 18 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12811 CERTIFICATE OF DEATH

Reg. Dist. No. 1279533

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 1903 E. NORTH AVENUE	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle KINDLE Last HOWE		4. DATE OF DEATH Month 12 Day 18 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10.10.03
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HOWE		14. MOTHER'S MAIDEN NAME EMMA MC BRIDE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) tuberculous meningitis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pulmonary tuberculosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 months 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0281 LATE LATENT SYPHILIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 26, 1956 , to December 19, 1957 , that I last saw the deceased alive on 12-19-57 , and that death occurred at 10:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Peters		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St. Paul St.	
24a. REC'D BY REGISTRAR DEC 24 1957		24b. REGISTRAR'S SIGNATURE Mary Elings	

BUREAU V. 3

DEC 24 1957

RECEIVED

12812

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 11 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS ROUTE #1			
3. NAME OF DECEASED (Type or print) First LeROY Middle J Last HULLIGER, SR.				4. DATE OF DEATH Month DECEMBER Day 22 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-16	
9. AGE (In years lost birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) PRESTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN L HULLIGER				14. MOTHER'S MAIDEN NAME ANNA KNOX			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-11		17. INFORMANT VET. ADM. HOSP., CLIN. RECORDS, FT HOWARD MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RHEUMATIC CARDIOVASCULAR DISEASE, AORTIC STENOSIS 411X MYXOMATOSIS AND INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 11, 19 57 to December 22, 19 57 , and that death occurred at 12:35 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 12/23/57 ACTUAL SIGNATURE Irving Freeman M.D. IRVING FREEMAN, M.D., Chief, Medical Service PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		22d. LOCATION (City, town, or county) (State) FEDERALSBURG, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton & Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DEC 26 1957		24b. REGISTRAR'S SIGNATURE Jawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DECEASED

HUSBAND

WIFE

CHILD

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

RELIGION

DATE

PLACE

DECEASED

DECEASED

BUREAU V. 1

DEC 27 1957

RECEIVED

12725 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>51 Arbutus 27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3900 Annapolis Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>M.</u> Last <u>Hyson</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 25, 1878</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Franklin W. Ascheneier, Jr., 3900 Annapolis Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V.D.</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>57</u> , to <u>Dec 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>57</u> , and that death occurred at <u>11 A</u> . M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Schinfeld</u> M.D.				ADDRESS (Street, city or town, state) <u>2301 Annapolis Rd.</u> DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 17 1957</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND

BUREAU V. 2

DEC 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

.12813

CERTIFICATE OF DEATH

12798 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bauernschmidt Manor</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Bauernschmidt Manor-Balto.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1, Box 727,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1, Box 727,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VACLAV JOSEPH JANATA</u>		4. DATE OF DEATH Month Day Year <u>December 4 19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 16, 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. Hardware</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Anton Janata</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Amelia Kotras, dght, above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>1 day</u> <u>6 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490X Lobar Pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1955</u> , to <u>Dec 4, 1957</u> , that I last saw the deceased alive on <u>Dec 4, 1957</u> , and that death occurred on <u>5459</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Miceli</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>108 S. TAYLOR AVE 12/6/57</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI, M.D.</u>		<u>ESSEX 21 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u>		ADDRESS <u>Funeral Home 3331 Brehms Lane</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE		OCCUPATION	
EDUCATION		MILITARY SERVICE	
PREVIOUS ILLNESS		TREATMENT	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER	
SIGNATURE OF CORONER		SIGNATURE OF JURY	

Continued from previous page

John P. ...

Dec 4 1957
Joseph ...
108 2 ...
1057

RECEIVED

BUREAU V. 3

CERTIFICATE OF DEATH

Reg. Dist. No.

43

12814

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OVERLEA</u>				c. LENGTH OF STAY IN 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7305 LINDEN AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARA V. GRIFFIN JOHNSON</u>				4. DATE OF DEATH Month Day Year <u>12 16 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 7. 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Wm. GRIFFIN</u>			
14. MOTHER'S MAIDEN NAME <u>HARRIETT HAMILTON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>ELIZABETH BARTZ-2009 N. FULTON AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO <u>hypertensive cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c) <u>stroke</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>syn</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>11-24-53</u> , 19 <u>53</u> , to <u>12-16-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-15</u> , 19 <u>57</u> , and that death occurred at <u>4:30</u> p.m. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Rigler</u> M.D. <u>1 W. Overlea Ave. Balto. Md. 12-16-57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. Richard R. Rigler</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		22d. LOCATION (City, town, or county) (State) <u>Larley, Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Schatzman</u>				ADDRESS <u>1701 M. & C. St. Balto. Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 19 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. K. R. R. R.</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____	
SIGNATURE OF JUDGE _____		SIGNATURE OF CLERK _____	

BUREAU V. S.

DEC 19 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12800
12815 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 35 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 WHITE MARSH (BALTO. 20)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 PARADISE NURSING HOME			d. STREET ADDRESS MOHRS LANE + POLASKI HWY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH JONES			4. DATE OF DEATH Month Day Year 12/7/57 19		
5. SEX FEM	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 APRIL 1888 69		9. AGE (In years last birthday) yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME CARR JACKSON		
14. MOTHER'S MAIDEN NAME MARY D. BRINKLEY			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. —			17. INFORMANT Address JAMES H. JONES, SAME		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x Hemiplegic Right. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/2/57	
20f. (City or town) 12/7/57		(County)		(State)	
21. I certify that I attended the deceased from 12/6/57 , 19 57 , to 12/7/57 , 19 57 , that I last saw the deceased alive on 12/6/57 , 19 57 , and that death occurred at 1045 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. E. McGrath			ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28md 12/7/57		
PHYSICIAN'S NAME (Type) W. E. McGrath			DATE DEC 9 '57		
22. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY JONES FAMILY PLOT 7 RURAL (SUNBURY, N. C.)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter D. Brady, Klenck, Md.			24a. REC'D BY REGISTRAR DEC 9 '57		
24b. REGISTRAR'S SIGNATURE W. E. McGrath					

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. DATE [Faint text]</p>	

BUREAU V. S.

DEC 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12726 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto Highlands		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2701 Yarnall Road		d. STREET ADDRESS 2701 Yarnall Road	
3. NAME OF DECEASED (Type or print) OLYMPIA-ELIZABETH KEIL		4. DATE OF DEATH Month Dec Day 11 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 8, 1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTH PLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Pierce		14. MOTHER'S MAIDEN NAME Mary E. Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles E. Keil		Address Mulberry Rd. Hanover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerotic Cardiovascular Disease DUE TO (c) None			INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/19 , 19 57 , to 12/11 , 19 57 , that I last saw the deceased alive on 12/11 , 19 57 , and that death occurred at 2:40 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph G. Laukaitis		DATE SIGNED 679 Washington Blvd	
PHYSICIAN'S NAME (Type) Joseph G. Laukaitis, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 14 1957	22c. NAME OF CEMETERY OR CREMATORY Western	22d. LOCATION (City, town, or county) (State) Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE John G. Orfel		24. REC'D BY REGISTRAR DEC 16 1957	
ADDRESS 5311 Edmondson Ave		24b. REGISTRAR'S SIGNATURE Geo M. Kieffer	

BUREAU V. S.

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12816 CERTIFICATE OF DEATH

12802

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 41 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 4613 Bellview Avenue			
3. NAME OF DECEASED (Type or print) First CARROLL Middle A. Last KETTLE				4. DATE OF DEATH Month December Day 20 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/13/10	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carroll Kettle				14. MOTHER'S MAIDEN NAME Nora Peach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-10-8520		17. INFORMANT Clin. Rec. Div, Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS PRIMARY SITE LUNG, LEFT 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year 19 p. m. _____		20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that VA attended the deceased from November 9, 1957 , to December 20, 1957 , and that death occurred at 12:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. VAH Fort Howard, Maryland 12/20/57 PHYSICIAN'S NAME (Type) C.J. PAPAISTRAT, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23 1957		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) 5608 Dogwood Rd., Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Willis E. Lamoreau				24. REC'D BY REGISTRAR DEC 23 1957		24b. REGISTRAR'S SIGNATURE D. L. Farber	

Willis E. Lamoreau 4510 Liberty Heights Ave. Balto., Md.

CERTIFICATE OF DEATH

NAME OF DECEASED CAROL ANN BAKER		SEX F		DATE OF BIRTH 10-10-1910		PLACE OF BIRTH BALTIMORE, MARYLAND	
RACE WHITE		HEIGHT 5' 0"		WEIGHT 110 LBS		BUILD MEDIUM	
OCCUPATION CLERK		MARITAL STATUS SINGLE		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
DECEASED AT 10:30 AM		PLACE OF DEATH BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. BAKER		SIGNATURE OF WITNESS J. H. BAKER		SIGNATURE OF DECEASED CAROL ANN BAKER		SIGNATURE OF NEXT OF KIN J. H. BAKER	
DATE OF DEATH 12-23-1957		PLACE OF DEATH BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	

BUREAU V. B.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Medical examiner notified and released body. 12727 CERTIFICATE OF DEATH

12803/2

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD COUNTY Baltimore 404 N. Rolling Road,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Relay Hill Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Horace Middle McClelland Last King		4. DATE OF DEATH Month 12 Day 26 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 7-1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none at present		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 37 yrs. IF UNDER 1 YEAR Months 3 Days 18 IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Park Avenue, New York City		12. CITIZEN OF WHAT COUNTRY? Citizen U.S.A.	
13. FATHER'S NAME C. Leroy King		14. MOTHER'S MAIDEN NAME Charlotte Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) U.S. Army		16. SOCIAL SECURITY NO. 414-26-4143	
17. INFORMANT Mother: Mrs. John S. Albert		Address Ridgeway 7-7416	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism with delirium DUE TO (b) Possible Barbiturate intoxication DUE TO (c) Chronic Alcoholism CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 wks. 17 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 23 , 19 57 , to Dec. 26 , 19 57 , that I last saw the deceased alive on Dec. 26 , 19 57 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Lewis P. Gundry M.D.		PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 28/57	22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE	22d. LOCATION (City, town, or county) (State) DORSEY MD
23. FUNERAL DIRECTOR'S SIGNATURE WILKE FUNERAL DIR. 4101 EDMONDSON		24a. REC'D BY REGISTRAR Dr. G. M. Gundry	24b. REGISTRAR'S SIGNATURE Dr. G. M. Gundry

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
J. L. Smith		1957	
RESIDENCE		PLACE OF DEATH	
1234 Main St., Baltimore, Md.		Home	
AGE		SEX	
65		Male	
DATE OF BIRTH		PLACE OF BIRTH	
1900		Maryland	
OCCUPATION		CAUSE OF DEATH	
Teacher		Heart Disease	
PREVIOUS ILLNESS		DATE OF INTERMENT	
None		1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. L. Smith		J. L. Smith	

BUREAU V. 1

DEC 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12817 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12804

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr11mth12dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Larchmont, Maryland		d. STREET ADDRESS 2505 Poplar Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle A. Last Knight		4. DATE OF DEATH Month Dec. Day 5 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown 12/9/18-
9. AGE (In years last birthday) 84? yrs.		IF UNDER 1 YEAR Months 84? Days 84?	IF UNDER 24 HRS. Hours 84? Min. 84?
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) fracture right hip DUE TO Accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Roger Sanderson Splint. use & Cast Symptomatic 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell from bench on 11-12-57 sustaining an intertrochanteric frac. of rt. hip			
20c. TIME OF INJURY Month, Day, Year 1:30 p. m. 11-12 1957		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	
20f. (City or town) Catonsville 28, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		DATE SIGNED 12-5-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/1957	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Brummett Per E. J. Brummett		24a. REC'D BY REGISTRAR DEC 9 '57	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. H. Smith	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12805
12818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>3 vol-4</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1205 Merediths Ford Road</i>		d. STREET ADDRESS <i>2227 Kentucky Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mr. Le Roy J. Koeneke</i>		4. DATE OF DEATH <i>December 25th 1957</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 6, 1911</i>
9. AGE (In years last birthday) <i>46</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk, Continental Can Co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Koeneke</i>		14. MOTHER'S MARRIED NAME <i>Catherine Dressler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Virginia Koeneke, 2227 Kentucky Av</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis Sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to</i> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12/26/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/30/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road.</i>		24a. REC'D BY REGISTRAR <i>DEC 30 1957</i>	
24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>			

RECEIVED

DEC 30 1967

BUREAU V. 4

12819 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3503 Midfield Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irving M Kolker</u>		4. DATE OF DEATH <u>12-14-1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>60</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Monish</u>		14. MOTHER'S MAIDEN NAME <u>Faga</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>War I</u>		16. SOCIAL SECURITY NO. <u>Rosa Kolker</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>few seconds</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 11</u> , 19 <u>57</u> , to <u>Dec 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 11</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Trescher</u> M.D.		ADDRESS (Street, city or town, state) <u>1035 N. Calvert St Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>John H. Trescher</u>		DATE SIGNED <u>Dec. 15, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Entwistle Place</u>		24a. REC'D BY REGISTRAR <u>DEC 18 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Jarothy Newell</u>	

BUREAU V. S.

DEC 18 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The form copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12721 CERTIFICATE OF DEATH

12807

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Dundalk</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>53 Dundalk</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7016 Dunhill Rd.</u>				STREET ADDRESS <u>7016 Dunhill Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u>		(Middle)		(Last) <u>KOPECNI</u>		(Month) (Day) (Year)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>October 10, 1883</u>	
9. AGE last birthday <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>brick layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>John Kopecni</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Anthony P. Kopecni 7016 Dunhill Rd.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardiac VASC. Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Brucella + Pulm. Emphysema</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 17, 1957</u> , to <u>Dec 12, 1957</u> , that I last saw the deceased alive on <u>Dec 11, 1957</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. D. Brown</u>				DATE SIGNED <u>Dec 12, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Dec. 14, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>M. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <u>Ullrich Funeral Homes, Balto., Md.</u>	
DATE <u>DEC 16 1957</u>							

CERTIFICATE OF DEATH

Reg. No. 111

C. (What was the cause of death?)

CAUSE OF DEATH

DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

AGE

SEX

SEX

RACE

RACE

EDUCATION

EDUCATION

OCCUPATION

OCCUPATION

RELIGION

RELIGION

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

AGE

SEX

SEX

RACE

RACE

EDUCATION

EDUCATION

OCCUPATION

OCCUPATION

RELIGION

RELIGION

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

AGE

SEX

SEX

RACE

RACE

EDUCATION

EDUCATION

OCCUPATION

OCCUPATION

RELIGION

RELIGION

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

AGE

SEX

SEX

RACE

RACE

EDUCATION

EDUCATION

OCCUPATION

OCCUPATION

RELIGION

RELIGION

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

AGE

SEX

SEX

RACE

RACE

EDUCATION

EDUCATION

OCCUPATION

OCCUPATION

RELIGION

RELIGION

DATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

AGE

AGE

SEX

SEX

RACE

RACE

EDUCATION

EDUCATION

BUREAU V. S.

DEC 16 1957

RECEIVED

200100151

12820

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34014 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		d. STREET ADDRESS 1807 Linden Ave.	
3. NAME OF DECEASED (Type or print) Adelaide First Middle Last Kratz		4. DATE OF DEATH Month 12 Day 7 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland, U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Nicholson		14. MOTHER'S MAIDEN NAME Eliza Musgrove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Alton Kratz (S on)		Address 332 Lambeth Road Catonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterioscler. Cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/28 , 19 57 , to 12/7 , 19 57 , that I last saw the deceased alive on 12/7 , 19 57 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar M.D.		ADDRESS (Street, city or town, state) Spring Grove State Hosp. DATE SIGNED 12/7/57	
PHYSICIAN'S NAME (Type) STELLA WACHSLER		Catonsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 10/57	22c. NAME OF CEMETERY OR CREMATORY Western Cemetery	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir.		ADDRESS 4101 Edmondson Ave/	
24a. REC'D BY REGISTRAR DATE DEC 10 57		24b. REGISTRAR'S SIGNATURE Rehner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

Register No.

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF REGISTRAR</p> <p>11. SIGNATURE OF DECEASED</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF FUNERAL HOME</p> <p>14. SIGNATURE OF MINISTER</p> <p>15. SIGNATURE OF CLERGY</p> <p>16. SIGNATURE OF OTHER</p> <p>17. SIGNATURE OF OTHER</p> <p>18. SIGNATURE OF OTHER</p> <p>19. SIGNATURE OF OTHER</p> <p>20. SIGNATURE OF OTHER</p>	
--	--

BUREAU V. S.

DEC 10 1937

RECEIVED

12821

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 Forest Avenue				d. STREET ADDRESS 116 Forest Avenue #28			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE LAVINIA KRIEB				4. DATE OF DEATH Month Day Year Dec. 7 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XXX DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1870	9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William F. Cain				14. MOTHER'S MAIDEN NAME Lavinia E. Glass			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Theodore Clark-116 Forest Avenue #28			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic hypertensive, cardio-vascular disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 wk 13 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr 20 , 19 44 , to Dec 7 , 19 57 , that I last saw the deceased alive on Dec 7 , 19 57 , and that death occurred at 10:12 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George A Knipp M.D.				ADDRESS (Street, city or town, state) 416 Edmondson Ave DATE SIGNED Dec 8 1957			
PHYSICIAN'S NAME (Type) George A Knipp M.D.				Baltimore, 29, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tibbels & Sons				24a. REC'D BY REGISTRAR DEC 9 57 24b. REGISTRAR'S SIGNATURE W. J. Tibbels			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES A. JONES		45		M		W		JAN 15 1910		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 15 1935		BALTIMORE, MD.		JANE A. JONES		DEC 10 1957		BALTIMORE, MD.	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		JUN 15 1935		BALTIMORE, MD.		JANE A. JONES		DEC 10 1957		BALTIMORE, MD.	
CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		DEC 10 1957		BALTIMORE, MD.		JANE A. JONES		DEC 10 1957		BALTIMORE, MD.	
MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		DEC 10 1957		BALTIMORE, MD.		JANE A. JONES		DEC 10 1957		BALTIMORE, MD.	
DATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
DEC 10 1957		DEC 10 1957		BALTIMORE, MD.		JANE A. JONES		DEC 10 1957		BALTIMORE, MD.	

BUREAU V. S.

DEC 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12822 CERTIFICATE OF DEATH

12810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				d. STREET ADDRESS 3501 Calloway Ave.			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLEN Middle BARBARA Last KUNKEL				4. DATE OF DEATH Month Dec. Day 4 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1890		9. AGE (In years last birthday) yrs. 67	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Grissinger				14. MOTHER'S MAIDEN NAME Sarah Jane Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Irvin T. Kunkel - 2113 Southland Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage (c) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/10 to 12/4 , 19 57 , that I last saw the deceased alive on 12/4 , 19 57 , and that death occurred at 12:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 679 Washington Blvd. Balto. 30, Md. DATE SIGNED 12/6/57 ACTUAL SIGNATURE Joseph G. Laukaitis M.D. PHYSICIAN'S NAME (Type) Joseph G. Laukaitis, M.D. 679 Washington Blvd. Balto. 30, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/7/57		22c. NAME OF CEMETERY OR CREMATORY Emanuel Cem.		22d. LOCATION (City, town, or county) (State) Lewisberry, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fischer & Sons Balto. 17				24a. REC'D BY REGISTRAR DATE DEC 9 '57		24b. REGISTRAR'S SIGNATURE Rebecca	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12811

12823 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b XO Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6001 Gwynn Oak Ave.		d. STREET ADDRESS 6001 Gwynn Oak Ave.	
3. NAME OF DECEASED (Type or print) First Ralph Middle Lange Last Lange		4. DATE OF DEATH Month Dec. Day 23 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Lange		14. MOTHER'S MAIDEN NAME Florence Speleshouse	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Florence Lange - 6001 Gwynn Oak Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - Generalized Arterio - Sclerosis - (c) - Cerebral Thrombosis - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis of Spine			
INTERVAL BETWEEN ONSET AND DEATH 8 yrs. 5 yrs. 1 wk.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 7 - 1954 , to Dec. 23, 1957 , that I last saw the deceased alive on Dec. 22, 1957 , and that death occurred at 12:27 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers M.D.		ADDRESS (Street, city or town, state) 4108 Liberty Hts Ave - Balto - Md. DATE SIGNED 12-23-57	
PHYSICIAN'S NAME (Type) Earl L. Chambers		4108 Liberty Hts Ave - Balto - Md. 12-23-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/24/57	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Crem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Tiekner & Sons - Balto		24a. REC'D BY REGISTRAR Dr. Jm. Mart...	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SEX		AGE	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARITAL STATUS		PREVIOUS MARRIAGES	
DATE OF MARRIAGE		NAME OF SPOUSE	
DATE OF DIVORCE		NAME OF SPOUSE	
DATE OF REMARRIAGE		NAME OF SPOUSE	
DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CITY OF DEATH	
STATE OF DEATH		COUNTY OF DEATH	
ZIP CODE		FEDERAL BUREAU OF INVESTIGATION	
DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CITY OF DEATH	
STATE OF DEATH		COUNTY OF DEATH	
ZIP CODE		FEDERAL BUREAU OF INVESTIGATION	

BUREAU V. &

DEC 27 1957

RECEIVED

12824

CERTIFICATE OF DEATH

12812

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 20 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 4201 RIDGEWOOD AVE			
3. NAME OF DECEASED (Type or print) First Middle Last AMELIA MARY LANTZ				4. DATE OF DEATH Month Day Year 12 19 1957			
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1867	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME FREDERICK WIENEKE				14. MOTHER'S MAIDEN NAME KATHERINE WAGONER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Frank L. Smith Jr.		Address Cockeysville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Cockeysville, Md		(County) (State)	
21. I certify that I attended the deceased from 7-19 , 1954, to 12-18 , 1957, that I last saw the deceased alive on 12-18 , 1957, and that death occurred at 12:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Hees				ADDRESS (Street, city or town, state) Cockeysville, Md			
DATE SIGNED DEC 23 1957							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-21-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24. REGISTRAR'S SIGNATURE W. J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF MARRIAGE OFFICIAL		20. SIGNATURE OF DIVORCE OFFICIAL		21. SIGNATURE OF PROBATE OFFICIAL	
22. SIGNATURE OF ESTATE OFFICIAL		23. SIGNATURE OF GUARDIAN		24. SIGNATURE OF TUTOR	
25. SIGNATURE OF ADMINISTRATOR		26. SIGNATURE OF EXECUTOR		27. SIGNATURE OF FIDELITY BOND	
28. SIGNATURE OF SURETY		29. SIGNATURE OF SURETY		30. SIGNATURE OF SURETY	
31. SIGNATURE OF SURETY		32. SIGNATURE OF SURETY		33. SIGNATURE OF SURETY	
34. SIGNATURE OF SURETY		35. SIGNATURE OF SURETY		36. SIGNATURE OF SURETY	
37. SIGNATURE OF SURETY		38. SIGNATURE OF SURETY		39. SIGNATURE OF SURETY	
40. SIGNATURE OF SURETY		41. SIGNATURE OF SURETY		42. SIGNATURE OF SURETY	
43. SIGNATURE OF SURETY		44. SIGNATURE OF SURETY		45. SIGNATURE OF SURETY	
46. SIGNATURE OF SURETY		47. SIGNATURE OF SURETY		48. SIGNATURE OF SURETY	
49. SIGNATURE OF SURETY		50. SIGNATURE OF SURETY		51. SIGNATURE OF SURETY	
52. SIGNATURE OF SURETY		53. SIGNATURE OF SURETY		54. SIGNATURE OF SURETY	
55. SIGNATURE OF SURETY		56. SIGNATURE OF SURETY		57. SIGNATURE OF SURETY	
58. SIGNATURE OF SURETY		59. SIGNATURE OF SURETY		60. SIGNATURE OF SURETY	
61. SIGNATURE OF SURETY		62. SIGNATURE OF SURETY		63. SIGNATURE OF SURETY	
64. SIGNATURE OF SURETY		65. SIGNATURE OF SURETY		66. SIGNATURE OF SURETY	
67. SIGNATURE OF SURETY		68. SIGNATURE OF SURETY		69. SIGNATURE OF SURETY	
70. SIGNATURE OF SURETY		71. SIGNATURE OF SURETY		72. SIGNATURE OF SURETY	
73. SIGNATURE OF SURETY		74. SIGNATURE OF SURETY		75. SIGNATURE OF SURETY	
76. SIGNATURE OF SURETY		77. SIGNATURE OF SURETY		78. SIGNATURE OF SURETY	
79. SIGNATURE OF SURETY		80. SIGNATURE OF SURETY		81. SIGNATURE OF SURETY	
82. SIGNATURE OF SURETY		83. SIGNATURE OF SURETY		84. SIGNATURE OF SURETY	
85. SIGNATURE OF SURETY		86. SIGNATURE OF SURETY		87. SIGNATURE OF SURETY	
88. SIGNATURE OF SURETY		89. SIGNATURE OF SURETY		90. SIGNATURE OF SURETY	
91. SIGNATURE OF SURETY		92. SIGNATURE OF SURETY		93. SIGNATURE OF SURETY	
94. SIGNATURE OF SURETY		95. SIGNATURE OF SURETY		96. SIGNATURE OF SURETY	
97. SIGNATURE OF SURETY		98. SIGNATURE OF SURETY		99. SIGNATURE OF SURETY	
100. SIGNATURE OF SURETY		101. SIGNATURE OF SURETY		102. SIGNATURE OF SURETY	

RECEIVED
BUREAU V. 1
DEC 23 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12813

12825

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Baltimore 22, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dolfield Road				d. STREET ADDRESS 1911 Wills Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stephen Middle Paul Last Lepus Jr.				4. DATE OF DEATH Month Dec. Day 14 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1934		9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	IF UNDER 24 HRS. Hours 23 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stephen Lepus Sr.				14. MOTHER'S MAIDEN NAME Helen Loneala			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2		17. INFORMANT Robert Lepus, 34 Riverside Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hooked hose onto automobile exhaust & ran same in car window.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Dec. 10 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods-Dolfield Rd., Owings Mills, Balto., Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary	
				22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kaczorowski Funeral Home				ADDRESS 2525 Fleet St Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 12-14-57	
				24b. REGISTRAR'S SIGNATURE Mary B. Zline			

DATE SIGNED

12-14-57

RECEIVED

DEC 17 1957

BUREAU V. S.

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12826

CERTIFICATE OF DEATH

Reg. Dist. No.

12814

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3401-4</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>			d. STREET ADDRESS <u>3606 Clarinthe Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SOLOMON</u> Middle <u>LEVINSON</u> Last <u>LEVINSON</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>24</u> Days <u>19</u> Hours <u>57</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Practice</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Max Levinson</u>		
14. MOTHER'S MAIDEN NAME <u>Bella Smith</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>PT.'s record</u>		
16. SOCIAL SECURITY NO. <u>_____</u>			17. INFORMANT <u>PT.'s record</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular</u> <u>422.1</u> DUE TO <u>coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis, generalized</u> DUE TO <u>coronary</u> (c) <u>_____</u>					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>			
20c. TIME OF INJURY Hour <u>a. 11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>	20f. (City or town) <u>_____</u>	(County) <u>_____</u>	(State) <u>_____</u>
21. I certify that I attended the deceased from <u>12-22</u> , 19 <u>57</u> , to <u>12-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-24</u> , 19 <u>57</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Sieela Wachslar</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp. 12/24/57</u>			
PHYSICIAN'S NAME (Type) <u>DR. S. WACHSLER</u>		DATE SIGNED <u>12/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State) <u>_____</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hebrew Burial Soc. Inc. 1124-26 W. North Ave.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 57</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12815

12827

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3 months 25 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				/ d. STREET ADDRESS 406 Register Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Carrie Middle Louise Last Lindauer		4. DATE OF DEATH Month December Day 5 Year 19 57					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Bald				14. MOTHER'S MAIDEN NAME Pauline Klein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records:: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, generalized and severe						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 27 , 19 57 , to Dec. 5 , 19 57 , that I last saw the deceased alive on Dec. 5 , 19 57 , and that death occurred at 3.15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12-5-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co 4905 York Road Baltimore 12, Md.				24a. REC'D BY REGISTRAR DATE 12/6/57		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12817

Reg. Dist. No.

.12829

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bank of Back River.		d. STREET ADDRESS 318 Oriole Avenue	
3. NAME OF DECEASED (Type or print) THOMAS JEFFERSON LYNN		4. DATE OF DEATH Month December Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 29, 1885
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 28 Hours 15 Min. 57	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		12. KIND OF BUSINESS OR INDUSTRY WEAVER.	
13. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME WILLIAM LYNN		16. MOTHER'S MAIDEN NAME MATILDA ?	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. 160-09-0214	
19. INFORMANT CATHERINE M. LYNN		20. ADDRESS SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, Found Drowned. 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="border: 1px solid black; padding: 5px;"> 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Found drowned. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 12/17 19 57 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work Back River 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Baltimore Md. 20f. (City or town) (County) (State) </div>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-21-57	
22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM		22d. LOCATION (City, town, or county) (State) 4300 OLD FREDERICK RD. BALTO, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Guiler		24a. REC'D BY REGISTRAR Edith Hawley	
ADDRESS 901 S. CONKLING ST. BALTO., MD.		DATE 12-18-57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. 1

DEC 23 1937

12/23/37

Found in road.

1/17/37

Brown, young, female.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MDA STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12828 CERTIFICATE OF DEATH

128138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 500 Fairway Court				d. STREET ADDRESS 3214 Kanyon Avenue			
3. NAME OF DECEASED (Type or print) First MARGARET Middle LYNCH Last				4. DATE OF DEATH Month December Day 11 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 4		IF UNDER 24 HRS. Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Bauer				14. MOTHER'S MAIDEN NAME Lena Frederick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT John C. Lynch, husband, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Peritonitis, abdominal (c) Carcinoma of Ovary.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Peritonitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1957 , to Dec 11, 1957 , that I last saw the deceased alive on Dec 8, 1957 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles E. Carr, Jr. M.D.				ADDRESS (Street, city or town, state) 6201 York Road Baltimore, Md.			
DATE SIGNED Dec. 13, 1957							
PHYSICIAN'S NAME (Type) Chas. E. Carr, Jr., M.D.				Baltimore 12, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/57		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home				24a. REC'D BY REGISTRAR DEC 16 1957			
ADDRESS 3331 Prohms Lane				24b. REGISTRAR'S SIGNATURE Robert Gray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES M. SMITH		45		M		W		JAN 15 1912		BALTIMORE		MD		USA	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		CITY OF DEATH		COUNTRY OF DEATH		CITY OF DEATH	
MARRIED		JAN 15 1935		BALTIMORE		MD		USA		BALTIMORE		MD		USA	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
HEART DISEASE		NATURAL		JAN 15 1957		BALTIMORE		MD		USA		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		CITY OF DEATH		COUNTRY OF DEATH		CITY OF DEATH	
JAMES M. SMITH		JAN 15 1957		BALTIMORE		MD		USA		BALTIMORE		MD		USA	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		CITY OF DEATH		COUNTRY OF DEATH		CITY OF DEATH	
JAMES M. SMITH		JAN 15 1957		BALTIMORE		MD		USA		BALTIMORE		MD		USA	

BUREAU V. S.

DEC 16 1957

RECEIVED

12818

12830

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 19yr8mth16dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4			
f. STREET ADDRESS UNKNOWN				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rosie Middle Last Mach				4. DATE OF DEATH Month December Day 1 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 60? yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Martin Mach				14. MOTHER'S MAIDEN NAME Mary Giza			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 30, 1957 , to Dec. 1, 1957 , that I last saw the deceased alive on Dec. 1, 1957 , and that death occurred at 1:00p.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-2-57							
ACTUAL SIGNATURE Stella Wachsler M.D.				PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) 1300 Dundalk Ave + Balto, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George A Weber 705 S Ann st				24a. REC'D BY REGISTRAR DATE DEC 4 '57		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED J. J. JONES		SEX Male		DATE OF BIRTH 1/1/1900		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		MARITAL STATUS Single		COLOR White		HEIGHT 5' 10"	
WEIGHT 150 lbs.		BUILD Medium		EYES Blue		HAIR Brown	
CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS 2 weeks		PLACE OF DEATH Home	
TIME OF DEATH 10:00 AM		DATE OF DEATH 12/15/1957		SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF REGISTRAR J. J. JONES	
SIGNATURE OF DECEASED J. J. JONES		SIGNATURE OF NEXT OF KIN J. J. JONES		SIGNATURE OF WITNESS J. J. JONES		SIGNATURE OF WITNESS J. J. JONES	

BUREAU V. 2

DEC 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12831

CERTIFICATE OF DEATH

12819/5

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aero Acres Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aero Acres Rural X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 48 Rt. Wing Drive				d. STREET ADDRESS 48 Rt. Wing Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur H. Middle Maddox Last 				4. DATE OF DEATH Month 12 Day 14 Year 57			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/29/1881	
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Land Owner		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bushrod Maddox		14. MOTHER'S MAIDEN NAME Lucy Weekley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Bessie L. Maddox		Address 48 Rt. Wing Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Dec 14 , 19 57 , to Dec 14 , 19 57 , that I last saw the deceased alive on Dec 14 , 19 57 , and that death occurred at 8:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 422 Eastern Ave. Baltimore 21, Md DATE SIGNED 12/16/57 ACTUAL SIGNATURE James J. White M.D. PHYSICIAN'S NAME (Type) 							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/57		22c. NAME OF CEMETERY OR CREMATORY St. Michaels Lutheran		22d. LOCATION (City, town, or county) (State) Perry Hall Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lasson Funeral Home				ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DEC 19 1957	
24b. REGISTRAR'S SIGNATURE Edith Hurley							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. POST-MORTEM EXAMINATION	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF INTERMENT		24. SIGNATURE OF BURIAL	
25. SIGNATURE OF INTERMENT		26. SIGNATURE OF BURIAL		27. SIGNATURE OF INTERMENT	
28. SIGNATURE OF BURIAL		29. SIGNATURE OF INTERMENT		30. SIGNATURE OF BURIAL	
31. SIGNATURE OF INTERMENT		32. SIGNATURE OF BURIAL		33. SIGNATURE OF INTERMENT	
34. SIGNATURE OF BURIAL		35. SIGNATURE OF INTERMENT		36. SIGNATURE OF BURIAL	
37. SIGNATURE OF INTERMENT		38. SIGNATURE OF BURIAL		39. SIGNATURE OF INTERMENT	
40. SIGNATURE OF BURIAL		41. SIGNATURE OF INTERMENT		42. SIGNATURE OF BURIAL	
43. SIGNATURE OF INTERMENT		44. SIGNATURE OF BURIAL		45. SIGNATURE OF INTERMENT	
46. SIGNATURE OF BURIAL		47. SIGNATURE OF INTERMENT		48. SIGNATURE OF BURIAL	
49. SIGNATURE OF INTERMENT		50. SIGNATURE OF BURIAL		51. SIGNATURE OF INTERMENT	
52. SIGNATURE OF BURIAL		53. SIGNATURE OF INTERMENT		54. SIGNATURE OF BURIAL	
55. SIGNATURE OF INTERMENT		56. SIGNATURE OF BURIAL		57. SIGNATURE OF INTERMENT	
58. SIGNATURE OF BURIAL		59. SIGNATURE OF INTERMENT		60. SIGNATURE OF BURIAL	
61. SIGNATURE OF INTERMENT		62. SIGNATURE OF BURIAL		63. SIGNATURE OF INTERMENT	
64. SIGNATURE OF BURIAL		65. SIGNATURE OF INTERMENT		66. SIGNATURE OF BURIAL	
67. SIGNATURE OF INTERMENT		68. SIGNATURE OF BURIAL		69. SIGNATURE OF INTERMENT	
70. SIGNATURE OF BURIAL		71. SIGNATURE OF INTERMENT		72. SIGNATURE OF BURIAL	
73. SIGNATURE OF INTERMENT		74. SIGNATURE OF BURIAL		75. SIGNATURE OF INTERMENT	
76. SIGNATURE OF BURIAL		77. SIGNATURE OF INTERMENT		78. SIGNATURE OF BURIAL	
79. SIGNATURE OF INTERMENT		80. SIGNATURE OF BURIAL		81. SIGNATURE OF INTERMENT	
82. SIGNATURE OF BURIAL		83. SIGNATURE OF INTERMENT		84. SIGNATURE OF BURIAL	
85. SIGNATURE OF INTERMENT		86. SIGNATURE OF BURIAL		87. SIGNATURE OF INTERMENT	
88. SIGNATURE OF BURIAL		89. SIGNATURE OF INTERMENT		90. SIGNATURE OF BURIAL	
91. SIGNATURE OF INTERMENT		92. SIGNATURE OF BURIAL		93. SIGNATURE OF INTERMENT	
94. SIGNATURE OF BURIAL		95. SIGNATURE OF INTERMENT		96. SIGNATURE OF BURIAL	
97. SIGNATURE OF INTERMENT		98. SIGNATURE OF BURIAL		99. SIGNATURE OF INTERMENT	
100. SIGNATURE OF BURIAL		101. SIGNATURE OF INTERMENT		102. SIGNATURE OF BURIAL	

RECEIVED
DEC 19 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12821

12832

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea Rural</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4201 Fullerton Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Augusta</u> Middle <u>Mallon</u> Last <u>Mallon</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seamstress</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Misikofski</u>		14. MOTHER'S MAIDEN NAME <u>Anna Bunk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>220-30-3604</u>	
17. INFORMANT <u>Miss Martha Mallon</u>		Address <u>4201 Fullerton Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO (b) <u>arterio sclerotic heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Fritz</u>		ADDRESS (Street, city or town, state) <u>2 W. University Pkwy Balto - 18 Md.</u>	
PHYSICIAN'S NAME (Type) <u>William Fritz</u>		DATE SIGNED <u>12/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Luth. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Howard County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lazarus Funeral Home 7401 Belair Rd.</u>		24. REC'D BY REGISTRAR <u>DEC 13 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Kefauver</u>			

RECEIVED

12833 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 8mths6dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3V01.4	
3. NAME OF DECEASED (Type or print) First Annie Middle E. Last Manning		4. DATE OF DEATH Month Dec. Day 7 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1876
9. AGE (In years last birthday) 81? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none NURSE-RET.		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Barthalomew MANNING		14. MOTHER'S MAIDEN NAME Ann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 21 , 19 57 , to Dec. 7 , 19 57 , that I last saw the deceased alive on Dec. 7 , 19 57 , and that death occurred at 11:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12-9-57	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 12-11-57	22c. NAME OF CEMETERY OR CREMATORY Catholictown Cem.	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Samuel Home - Catonsville, Md		24a. REC'D BY REGISTRAR DATE DEC 12 '57	
		24b. REGISTRAR'S SIGNATURE Overman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Page One

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES EARL RAY		M		35		W		12/1/57		MEMPHIS, TENN		12/4/57		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
None		None		Single		None		None		None		None		None		None		None		None		None	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

DEC 12 1957

RECEIVED

12834

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xo Riderwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8112 Rider Ave.				d. STREET ADDRESS 8112 Rider Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Lila Middle R. Last March				4. DATE OF DEATH Month December Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 3, 1867		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher		10b. KIND OF BUSINESS OR INDUSTRY Music		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William G. March				14. MOTHER'S MAIDEN NAME Jeanette Boyd MacLaughlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Claire McDonnell Worthington Address 8112 Rider Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 MOS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1957 , to Dec 27, 1957 , that I last saw the deceased alive on Dec 21, 1957 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Pillsbury M.D.				ADDRESS (Street, city or town, state) TIMONIAN, MD. DATE SIGNED 12/27/57			
PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc 1050 N. York Rd, Towson				24a. REC'D BY REGISTRAR 12/30/57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

4

M

13

1

2

VS A15 (4)
ISM 9/55

12835

128824 38

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Baltimore Co. MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Georgia b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 10 mos. 16 da. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlanta 49X-3 ✓

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard & Enoch Pratt Hosp. Towson 4, Md. d. STREET ADDRESS 875 W. Paces Ferry Road, N. W. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last Rembert Marshall 4. DATE OF DEATH Month Day Year December 28 1957

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Sept. 22, 1892 9. AGE (In years lost birthday) 65 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer 10b. KIND OF BUSINESS OR INDUSTRY law office 11. BIRTHPLACE (State or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Marshall 14. MOTHER'S MAIDEN NAME Ella Holton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. I 16. SOCIAL SECURITY NO. 17. INFORMANT Hospital records Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 177X Uremia
DUE TO (b) Generalized carcinomatosis 4 mo.
DUE TO (c) Carcinoma of prostate 18 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 12, 1957, to Dec. 28, 1957, that I last saw the deceased alive on December 28, 1957, and that death occurred at 10:25 AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED 12/28/57
ACTUAL SIGNATURE Harry M. Murdock M.D. M.D.
PHYSICIAN'S NAME (Type) Harry M. Murdock, M.D. Sheppard & Enoch Pratt Hosp. Towson 4, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Dec. 31, 1957 22c. NAME OF CEMETERY OR CREMATORY West View 22d. LOCATION (City, town, or county) (State) Atlanta, Ga.

23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. ADDRESS 1900 Eutaw Place 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE JAN 2 1958 Mabel Gray

doi:10.1017/S0022292412001615

BUREAU V. S.

JAN 2 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12836

CERTIFICATE OF DEATH

12825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2mths 29dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.			
f. STREET ADDRESS 8601 - 49th Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jessie Middle F. Last Martin				4. DATE OF DEATH Month December Day 2 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 26/1863	
9. AGE (In years last birthday) 94? yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) UNKNOWN Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY At hoem			
13. FATHER'S NAME Thomas G. Horton				14. MOTHER'S MAIDEN NAME UNKNOWN Lucy Prentiss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or None (If yes, give war or dates of service)) unknown None				16. SOCIAL SECURITY NO. None			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 29 , 19 57 , to Dec. 2 , 19 57 , that I last saw the deceased alive on Dec. 2 , 19 57 , and that death occurred at 7:15 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 12-2-57							
ACTUAL SIGNATURE Stella Wachsler M.D.				DATE SIGNED 12-2-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/1957		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS Liversdale 2nd		24a. REC'D BY REGISTRAR DEC 9 '57	
24b. REGISTRAR'S SIGNATURE Quench							

21/09/2015

BUREAU V. S.

DEC 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 47

12837

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Halethorpe (Westland Gardens)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4804 Eldon Green Westland Gardens 27</u>				d. STREET ADDRESS <u>4804 Eldon Green</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Alvin Mason</u>				4. DATE OF DEATH Month Day Year <u>December 7 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1889</u>	
9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>68</u>		IF UNDER 24 HRS. <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret'd)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Vernon, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George B. Mason</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.I</u>				16. SOCIAL SECURITY NO. <u>217-01-0122</u>		17. INFORMANT Address <u>Bertha M. Mason, 4804 Eldon Garden</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LOWER THIRD ESOPHAGUS TO METASTASIS</u> DUE TO (b) <u>150X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ESOPHAGUS TO METASTASIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>150X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>57</u> , to <u>12/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/7</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5800 Edmondson Ave. # 28</u> DATE SIGNED <u>DEC 11 1957</u>							
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 Edmondson Ave. # 28</u>							
PHYSICIAN'S NAME (Type) <u>John H. Shaw, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 11 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. Geo. M. Kupper</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED		2. SEX		3. AGE		4. PLACE OF BIRTH	
5. OCCUPATION		6. MARITAL STATUS		7. DATE OF DEATH		8. TIME OF DEATH	
9. CAUSE OF DEATH		10. MANNER OF DEATH		11. PLACE OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CLERGYMAN	
17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE		19. SIGNATURE OF INTERMENT		20. SIGNATURE OF RECORDS	
21. SIGNATURE OF VITALS		22. SIGNATURE OF DEATH		23. SIGNATURE OF DEATH		24. SIGNATURE OF DEATH	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH		28. SIGNATURE OF DEATH	
29. SIGNATURE OF DEATH		30. SIGNATURE OF DEATH		31. SIGNATURE OF DEATH		32. SIGNATURE OF DEATH	
33. SIGNATURE OF DEATH		34. SIGNATURE OF DEATH		35. SIGNATURE OF DEATH		36. SIGNATURE OF DEATH	
37. SIGNATURE OF DEATH		38. SIGNATURE OF DEATH		39. SIGNATURE OF DEATH		40. SIGNATURE OF DEATH	
41. SIGNATURE OF DEATH		42. SIGNATURE OF DEATH		43. SIGNATURE OF DEATH		44. SIGNATURE OF DEATH	
45. SIGNATURE OF DEATH		46. SIGNATURE OF DEATH		47. SIGNATURE OF DEATH		48. SIGNATURE OF DEATH	
49. SIGNATURE OF DEATH		50. SIGNATURE OF DEATH		51. SIGNATURE OF DEATH		52. SIGNATURE OF DEATH	
53. SIGNATURE OF DEATH		54. SIGNATURE OF DEATH		55. SIGNATURE OF DEATH		56. SIGNATURE OF DEATH	
57. SIGNATURE OF DEATH		58. SIGNATURE OF DEATH		59. SIGNATURE OF DEATH		60. SIGNATURE OF DEATH	
61. SIGNATURE OF DEATH		62. SIGNATURE OF DEATH		63. SIGNATURE OF DEATH		64. SIGNATURE OF DEATH	
65. SIGNATURE OF DEATH		66. SIGNATURE OF DEATH		67. SIGNATURE OF DEATH		68. SIGNATURE OF DEATH	
69. SIGNATURE OF DEATH		70. SIGNATURE OF DEATH		71. SIGNATURE OF DEATH		72. SIGNATURE OF DEATH	
73. SIGNATURE OF DEATH		74. SIGNATURE OF DEATH		75. SIGNATURE OF DEATH		76. SIGNATURE OF DEATH	
77. SIGNATURE OF DEATH		78. SIGNATURE OF DEATH		79. SIGNATURE OF DEATH		80. SIGNATURE OF DEATH	
81. SIGNATURE OF DEATH		82. SIGNATURE OF DEATH		83. SIGNATURE OF DEATH		84. SIGNATURE OF DEATH	
85. SIGNATURE OF DEATH		86. SIGNATURE OF DEATH		87. SIGNATURE OF DEATH		88. SIGNATURE OF DEATH	
89. SIGNATURE OF DEATH		90. SIGNATURE OF DEATH		91. SIGNATURE OF DEATH		92. SIGNATURE OF DEATH	
93. SIGNATURE OF DEATH		94. SIGNATURE OF DEATH		95. SIGNATURE OF DEATH		96. SIGNATURE OF DEATH	
97. SIGNATURE OF DEATH		98. SIGNATURE OF DEATH		99. SIGNATURE OF DEATH		100. SIGNATURE OF DEATH	

BUREAU V. S.

DEC 11 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12838 CERTIFICATE OF DEATH

12827
Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>921 ELLENDALE DRIVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EVELYN C MAST</u>				4. DATE OF DEATH <u>DEC. 13 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1916</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. Elmer Blakeley</u>				14. MOTHER'S MAIDEN NAME <u>Anna E. Finn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Mast, Providence, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AD</u> DUE TO (c) <u>ADENOCARCINOMA OF OVARY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>14 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/24, 1957</u> to <u>12/13, 1957</u> , that I last saw the deceased alive on <u>12/12, 1957</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald L. Somerville</u> M.D. <u>25 W. Pa. Ave.</u>				ADDRESS (Street, city or town, state) <u>Towson & Md</u> DATE SIGNED <u>12/13/57</u>			
PHYSICIAN'S NAME (Type) <u>DONALD L. SOMERVILLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u> ADDRESS <u>Towson, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 15, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel C Gray</u>	

BUREAU V. S.

DEC 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the body for burial, cremation, or removal, and in any event within 72 hours after death. Page 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12839 CERTIFICATE OF DEATH

Reg. Dist. No.

12828

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Towson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sheppard Enoch Pratt Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Branch McAdams</u>				4. DATE OF DEATH Month Day Year <u>Dec. 31 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 12, 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President-Union Trust</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George B. McAdams</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Reade Branch</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Term.</u> <u>3 yr +</u> <u>3 yr +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Senile Brain Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>55</u>	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Oct 18, 1955</u> to <u>Dec 31, 1957</u> , that I last saw the deceased alive on <u>Dec 31</u> 19 <u>57</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.W. Elogin</u>				ADDRESS (Street, city or town, state) <u>Sheppard Pratt Hosp. Towson - 4, Md.</u>			
PHYSICIAN'S NAME (Type) <u>W.W. Elogin</u>				DATE SIGNED <u>1/1/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Richmond, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co., Inc.</u> <u>1905 York Rd., Balto. 12, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 6 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>			

BUREAU V. S.

JAN 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12840
CERTIFICATE OF DEATH

12829

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Glyndon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Central Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle J. McDonnell Last		4. DATE OF DEATH Month Dec. Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1896
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed by Baltimore County		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James P. McDonnell		14. MOTHER'S MAIDEN NAME Julia Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.1		16. SOCIAL SECURITY NO. 220-12-5956	
17. INFORMANT Mrs. Margaret G. McDonnell, Glyndon, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic C-V Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 7-31-47 , 19____, to 12-14-57 , 19____, that I last saw the deceased alive on 12-14-57 , 19____, and that death occurred at 10:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE D. D. Caples		ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 12-16-57	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 18, 1957	
22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or county) (State) Reisterstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE 12-16-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

FILE NO.

ACCOUNT NO.

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. S.

DEC 20 1957

RECEIVED

Item: 16 Film G223 12/10/57 SM CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 120 LANVALE ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ALBERT Middle DAVID Last McFADDEN				4. DATE OF DEATH Month 12 Day 4 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/9/18	
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months 3 Days 1 Hours 4 Min.		IF UNDER 24 HRS. Months 3 Days 1 Hours 4 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE BROKER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALBERT D. McFADDEN				14. MOTHER'S MAIDEN NAME SUSAN BURNS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-03-1574		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS ACTIVE 12 months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FAR ADVANCED (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FATTY DEGENERATION OF LIVER							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/30 , 1957, to 12/4 , 1957, that I last saw the deceased alive on 12/3 , 1957, and that death occurred at 12:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED							
ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland							
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial Dec 7/17		Dec 7/17		Greenfield		Pikesville Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Steele and Sons, 1000 N. Baltimore				24a. REC'D BY REGISTRAR DEC 6 1957		24b. REGISTRAR'S SIGNATURE Howthy Jewell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

PLACE OF BIRTH ALBANY, NEW YORK		PLACE OF DEATH ALBANY, NEW YORK	
DATE OF BIRTH 12/12/1912		DATE OF DEATH 12/12/1912	
SEX MALE		RACE WHITE	
NAME OF DECEASED ALBERT J. McFADDEN		NAME OF DECEASED ALBERT J. McFADDEN	
ADDRESS OF DECEASED 120 W. 10th St., Albany, N.Y.		ADDRESS OF DECEASED 120 W. 10th St., Albany, N.Y.	
OCCUPATION None		OCCUPATION None	
CAUSE OF DEATH Myocardial Infarction		CAUSE OF DEATH Myocardial Infarction	
PLACE OF INTERMENT None		PLACE OF INTERMENT None	
SIGNATURE OF DECEASED None		SIGNATURE OF DECEASED None	
SIGNATURE OF WITNESSES None		SIGNATURE OF WITNESSES None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF PHYSICIAN None	
SIGNATURE OF CORONER None		SIGNATURE OF CORONER None	
SIGNATURE OF REGISTRAR None		SIGNATURE OF REGISTRAR None	

RECEIVED
 DEC 6 1957
 BUREAU V. S.

12842 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1917 Hillside Ave.</u>				d. STREET ADDRESS <u>1917 Hillside Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martha E. McGinnis</u>				4. DATE OF DEATH Month Day Year <u>Dec. 24 1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 12, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Vernon Saker</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Wm. G. McGinnis Jr.</u> Address <u>6411 Kriel Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.1</u> DUE TO <u>Acute Pulmonary Edema</u> <u>Calapic Aortic Dissection & Aortic Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hour</u> <u>3 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8-2</u> , 19 <u>55</u> , to <u>12-24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>57</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon Ashman</u> M.D. <u>5907 Gwynn Oak Ave. #7</u> 12-24-57				DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Leon Ashman</u>				5907 Gwynn Oak Ave. #7			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Pandles town md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. J. H. Martin</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12832
12843 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) Ethel Regina MCNAMEE			2. DATE OF DEATH Dec. 26, 1957		
3. PLACE OF DEATH: A. Baltimore City, Maryland B. Baltimore County			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.		
5. FULL NAME OF HOSPITAL OR INSTITUTION 424 Overbrook Road			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) XO Baltimore		
6. LENGTH OF STAY IN BALTIMORE Life			D. STREET ADDRESS (If rural, give location) 424 Overbrook Road		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 26, 1897	9. AGE (In years last birthday) 60	10. UNDER 1 Year Months: Days 11 Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY ----		
13. FATHER'S NAME William J. McLaughlin			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
16. SOCIAL SECURITY NO. None			14. MOTHER'S MAIDEN NAME Marv E. Doyle		
17. INFORMANT Mr. Joseph P. McNamee			ADDRESS Road 424 Overbrook		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carcinoma of caecum with generalized metastasis		1 yr.
DUE TO		
153X ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
DUE TO		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION April 10, 1957	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of caecum	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. DATE OF INJURY December 5, 1957	21B. HOW DID INJURY OCCUR? While at work	

22. I certify that (I) (this hospital) attended the deceased from **March 25, 1957** to **December 26, 1957**, that (I) (we) last saw the deceased alive on **December 26, 1957**, and that death occurred at **5:30 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE Lloyd E. Saylor		23B. ADDRESS 5902 Greenmount Avenue #18	23C. DATE SIGNED 12/27/57
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/30/57	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery Baltimore, Maryland	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR DEC 29 1957	REGISTRAR'S SIGNATURE John A. Moran	25. FUNERAL DIRECTOR John A. Moran	ADDRESS 3000 E. Baltimore St.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

BUREAU V. S.

JAN 2 1953

RECEIVED

12844

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>5 yrs.</u>				d. STREET ADDRESS <u>3815 Monterey Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Margay</u> Middle <u>Louise</u> Last <u>Meinert</u>		4. DATE OF DEATH		Month <u>12</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/47</u>	9. AGE (In years last birthday) <u>10</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jerome Eugene Meinert</u>				14. MOTHER'S MAIDEN NAME <u>Georgeanna Austin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cerebral Spastic Infantile Paralysis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>since birth</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>12/30</u> , 19 <u>57</u> to <u>12/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/30</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/31/57</u>							
ACTUAL SIGNATURE <u>Olive Reid Harris, M.D.</u>				PHYSICIAN'S NAME (Type) <u>Olive Reid Harris, M.D.</u> <u>Rosewood State Training School</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>		22b. DATE THEREOF <u>12. 31. 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gr. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.H. Newell Inc. - Pikesville</u>				24a. REC'D BY REGISTRAR DATE <u>1/2/58</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filled with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

© 2011 Pearson Education, Inc. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or by any information storage or retrieval system, without prior written permission from the publisher.

BUREAU V. S.

JAN 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 29yr6mth26dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1006 Hanover Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Moffitt Last				4. DATE OF DEATH Month December Day 3 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-??		9. AGE (In years last birthday) 82? yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Rollhoff			14. MOTHER'S MAIDEN NAME Anna ??				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records ; SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.7 Acute cardiac failure DUE TO (b) Arteriovascular disease DUE TO (c) fracture left hip accident CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) on way to cafeteria sustaining fractured left hip. Pt. fell on steps					
20c. TIME OF INJURY Month, Day, Year 6:45 a.m. 11-20-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-6-57		22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM		22d. LOCATION (City, town, or county) (State) 4300 OLD FREDERICK RD. MD BALTO	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Feiler				24a. REC'D BY REGISTRAR 4015 CONKLING ST. BALTO, 24, MD.		24b. REGISTRAR'S SIGNATURE DEC 9 '57	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the deceased. Page 5 may be retained for the file of the deceased. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE DECEASED

NAME

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

PRESENT RESIDENCE

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. S.

DEC-10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12846 CERTIFICATE OF DEATH

1283538

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				d. STREET ADDRESS 315 E. North Ave.			
3. NAME OF DECEASED (Type or print) First SARA Middle ROBERTA Last MOONEY				4. DATE OF DEATH Month Dec. Day 11 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1876	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Miles				14. MOTHER'S MAIDEN NAME Elizabeth McFarland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Nelson F. Hurley - 411 Hollen Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Balto.		(County) (State)	
21. I certify that I attended the deceased from Nov 22, 1957 to Dec 11, 1957 , that I last saw the deceased alive on Fri Dec 6th, 1957 , and that death occurred at 2 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathaniel M Beck				ADDRESS (Street, city or town, state) 2818 St Paul St Balto Md			
PHYSICIAN'S NAME (Type) Nathaniel M Beck				DATE SIGNED Dec 12 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/13/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) Balto. 17 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Lickner & Sons - Balto 17 Md				24a. REC'D BY REGISTRAR DATE 12/13/57		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 and 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5 and 6 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12847

CERTIFICATE OF DEATH

12836

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2mths20dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 415 Augusta Ave.			
3. NAME OF DECEASED (Type or print) First Annie Middle Neuman Last Muhlbauer				4. DATE OF DEATH Month December Day 15 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Catonsville, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pyelonephritis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 25, 1957 , to Dec. 15, 1957 , that I last saw the deceased alive on Dec. 15, 1957 , and that death occurred at 12:50 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Stella Wachslar				DATE SIGNED SPRING GROVE STATE HOSPITAL 12-15-57			
ACTUAL SIGNATURE Stella Wachslar				M.D. Catonsville 28, Maryland			
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.							
22a. BURIAL, CREMATION, REBURY (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-19-1957		ST. MATTHEWS CEM.		BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schuch				ADDRESS 3512 Frederick Ave. (29)		24a. REC'D BY REGISTRAR DATE DEC 17 57	
				24b. REGISTRAR'S SIGNATURE Outreach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING 18
1957
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-1-22		6. BIRTH PLACE Memphis, Tenn.	
7. DEATH DATE 6-6-68		8. DEATH PLACE Memphis, Tenn.		9. DEATH TIME 10:00 PM	
10. DEATH CAUSE Heart Disease		11. DEATH PLACE Hospital		12. DEATH TIME 10:00 PM	
13. DEATH CAUSE Heart Disease		14. DEATH PLACE Hospital		15. DEATH TIME 10:00 PM	
16. DEATH CAUSE Heart Disease		17. DEATH PLACE Hospital		18. DEATH TIME 10:00 PM	
19. DEATH CAUSE Heart Disease		20. DEATH PLACE Hospital		21. DEATH TIME 10:00 PM	
22. DEATH CAUSE Heart Disease		23. DEATH PLACE Hospital		24. DEATH TIME 10:00 PM	
25. DEATH CAUSE Heart Disease		26. DEATH PLACE Hospital		27. DEATH TIME 10:00 PM	
28. DEATH CAUSE Heart Disease		29. DEATH PLACE Hospital		30. DEATH TIME 10:00 PM	
31. DEATH CAUSE Heart Disease		32. DEATH PLACE Hospital		33. DEATH TIME 10:00 PM	
34. DEATH CAUSE Heart Disease		35. DEATH PLACE Hospital		36. DEATH TIME 10:00 PM	
37. DEATH CAUSE Heart Disease		38. DEATH PLACE Hospital		39. DEATH TIME 10:00 PM	
40. DEATH CAUSE Heart Disease		41. DEATH PLACE Hospital		42. DEATH TIME 10:00 PM	
43. DEATH CAUSE Heart Disease		44. DEATH PLACE Hospital		45. DEATH TIME 10:00 PM	
46. DEATH CAUSE Heart Disease		47. DEATH PLACE Hospital		48. DEATH TIME 10:00 PM	
49. DEATH CAUSE Heart Disease		50. DEATH PLACE Hospital		51. DEATH TIME 10:00 PM	
52. DEATH CAUSE Heart Disease		53. DEATH PLACE Hospital		54. DEATH TIME 10:00 PM	
55. DEATH CAUSE Heart Disease		56. DEATH PLACE Hospital		57. DEATH TIME 10:00 PM	
58. DEATH CAUSE Heart Disease		59. DEATH PLACE Hospital		60. DEATH TIME 10:00 PM	
61. DEATH CAUSE Heart Disease		62. DEATH PLACE Hospital		63. DEATH TIME 10:00 PM	
64. DEATH CAUSE Heart Disease		65. DEATH PLACE Hospital		66. DEATH TIME 10:00 PM	
67. DEATH CAUSE Heart Disease		68. DEATH PLACE Hospital		69. DEATH TIME 10:00 PM	
70. DEATH CAUSE Heart Disease		71. DEATH PLACE Hospital		72. DEATH TIME 10:00 PM	
73. DEATH CAUSE Heart Disease		74. DEATH PLACE Hospital		75. DEATH TIME 10:00 PM	
76. DEATH CAUSE Heart Disease		77. DEATH PLACE Hospital		78. DEATH TIME 10:00 PM	
79. DEATH CAUSE Heart Disease		80. DEATH PLACE Hospital		81. DEATH TIME 10:00 PM	
82. DEATH CAUSE Heart Disease		83. DEATH PLACE Hospital		84. DEATH TIME 10:00 PM	
85. DEATH CAUSE Heart Disease		86. DEATH PLACE Hospital		87. DEATH TIME 10:00 PM	
88. DEATH CAUSE Heart Disease		89. DEATH PLACE Hospital		90. DEATH TIME 10:00 PM	
91. DEATH CAUSE Heart Disease		92. DEATH PLACE Hospital		93. DEATH TIME 10:00 PM	
94. DEATH CAUSE Heart Disease		95. DEATH PLACE Hospital		96. DEATH TIME 10:00 PM	
97. DEATH CAUSE Heart Disease		98. DEATH PLACE Hospital		99. DEATH TIME 10:00 PM	
100. DEATH CAUSE Heart Disease		101. DEATH PLACE Hospital		102. DEATH TIME 10:00 PM	

RECEIVED
DEC 17 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12837

12848 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Balto., 4 c. LENGTH OF STAY IN b Approx. 2 1/2 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 117 Stevenson Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Anna Beatrice Murray				4. DATE OF DEATH Month Day Year December 10 19 57									
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 14, 1880		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland				11. BIRTHPLACE (State or foreign country) U.S.A.					
13. FATHER'S NAME John McGinnis				14. MOTHER'S MAIDEN NAME Catherine Mulligan									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Admission Record		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency from DUE TO Generalized Arteriosclerosis (c) 8 Yrs INTERVAL BETWEEN ONSET AND DEATH 2 Months													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from June , 19 57 , to December , 19 57 , that I last saw the deceased alive on December 10 , 19 57 , and that death occurred at 117 Stevenson Lane , from the causes and on the date stated above.													
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				ADDRESS (Street, city or town, state) 7501 York Rd Baltimore, Md				DATE SIGNED 12/10/57					
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 12/13/57		22c. NAME OF CEMETERY OR CREMATORY ST. JOS. TEXAS		22d. LOCATION (City, town, or county) (State) BALTO Co.					
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. O'Donnell				ADDRESS 7501 York Rd Baltimore, Md		24a. REC'D BY REGISTRAR DATE 12/11/57		24b. REGISTRAR'S SIGNATURE Mabel Gray					

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

BUREAU V. S.

DEC 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12849

CERTIFICATE OF DEATH

Reg. Dist. No. 12838

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural-Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 62 625 Warwick Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUGUSTA Middle S. Last NAUMANN				4. DATE OF DEATH Month DEC Day 16 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Herman F. Rahnis				14. MOTHER'S MAIDEN NAME Louise Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-07-1014		17. INFORMANT Address Mrs. James Pearre 625 Warwick Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA 199.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALNUTRITION						INTERVAL BETWEEN ONSET AND DEATH 10-15 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from OCTOBER , 19 57 , to DECEMBER , 19 57 , that I last saw the deceased alive on 16 DEC , 19 57 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1600 Wilkens Ave Balto. 23, Md. DATE SIGNED 16 Dec 57 ACTUAL SIGNATURE H. H. Baylus PHYSICIAN'S NAME (Type) H. H. BAYLUS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOHN F. DENNY, INC. 715 Light St. -30				24a. REC'D BY REGISTRAR DATE DEC 20 57		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		C		M		H		C		C		C		C	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGICAL OPERATIONS	
JAN 1 1932		MEMPHIS, TENN		JUN 6 1968		MEMPHIS, TENN		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		ANGINA PECTORIS		MYOCARDIAL INFARCTION		PERICARDITIS	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE		FATHER'S DATE OF DEATH	
JAMES EARL RAY		JANET RAY		C		H		H		H		C		C		C		C		C	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH	
JAN 1 1900		JAN 1 1900		C		H		C		H		C		H		C		H		C	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S EDUCATION		MOTHER'S EDUCATION		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S RESIDENCE		MOTHER'S RESIDENCE		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH	
C		H		H		H		C		C		C		C		C		C		C	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S DISEASE OR INJURY		MOTHER'S DISEASE OR INJURY		FATHER'S MEDICAL HISTORY		MOTHER'S MEDICAL HISTORY		FATHER'S HISTORY OF PRESENT ILLNESS	
C		C		C		C		C		C		C		C		C		C		C	
FATHER'S HISTORY OF PREVIOUS ILLNESSES		MOTHER'S HISTORY OF PREVIOUS ILLNESSES		FATHER'S HISTORY OF SURGICAL OPERATIONS		MOTHER'S HISTORY OF SURGICAL OPERATIONS		FATHER'S HISTORY OF TRAUMA		MOTHER'S HISTORY OF TRAUMA		FATHER'S HISTORY OF DRUG ABUSE		MOTHER'S HISTORY OF DRUG ABUSE		FATHER'S HISTORY OF ALCOHOL ABUSE		MOTHER'S HISTORY OF ALCOHOL ABUSE		FATHER'S HISTORY OF OTHER ADDICTIONS	
C		C		C		C		C		C		C		C		C		C		C	
FATHER'S HISTORY OF OTHER ADDICTIONS		MOTHER'S HISTORY OF OTHER ADDICTIONS		FATHER'S HISTORY OF MENTAL ILLNESS		MOTHER'S HISTORY OF MENTAL ILLNESS		FATHER'S HISTORY OF PHYSICAL ILLNESS		MOTHER'S HISTORY OF PHYSICAL ILLNESS		FATHER'S HISTORY OF SOCIAL PROBLEMS		MOTHER'S HISTORY OF SOCIAL PROBLEMS		FATHER'S HISTORY OF LEGAL PROBLEMS		MOTHER'S HISTORY OF LEGAL PROBLEMS		FATHER'S HISTORY OF OTHER PROBLEMS	
C		C		C		C		C		C		C		C		C		C		C	
FATHER'S HISTORY OF OTHER PROBLEMS		MOTHER'S HISTORY OF OTHER PROBLEMS		FATHER'S HISTORY OF DEATH		MOTHER'S HISTORY OF DEATH		FATHER'S HISTORY OF BURIAL		MOTHER'S HISTORY OF BURIAL		FATHER'S HISTORY OF CREMATION		MOTHER'S HISTORY OF CREMATION		FATHER'S HISTORY OF OTHER FUNERAL ARRANGEMENTS		MOTHER'S HISTORY OF OTHER FUNERAL ARRANGEMENTS		FATHER'S HISTORY OF OTHER REMAINS	
C		C		C		C		C		C		C		C		C		C		C	

BUREAU V. S.

DEC 20 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12850 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ewings Mills</i>	c. LENGTH OF STAY IN 1b <i>18 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Ewings Mills.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Deer Park Rd.</i>		d. STREET ADDRESS <i>1 Deer Park Rd.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>JOSEPH PETER NAWROT</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>4</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 14, 1884</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Car man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rail Road</i>	11. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Simon Luke Nawrot</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Stochaj</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>1916</i>		16. SOCIAL SECURITY NO. <i>710-09-6425</i>	
17. INFORMANT <i>Bridget Nawrot</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion.</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost, DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>18 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None.</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>None 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>None</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D. D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>12-4-1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-7-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Family</i>	22d. LOCATION (City, town, or county) (State) <i>Holbrook, Balt. Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i>		ADDRESS <i>Clydeville, Md.</i>	
24a. REC'D BY REGISTRAR <i>DEC 6 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary Eliza</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE	
SIGNATURE OF EXAMINER		DATE		TIME	
LOCALITY		COUNTY		STATE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	
RECEIVED		DEC 6 1957		BUREAU V. S.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Film G-224 1/6/58. **CERTIFICATE OF DEATH**

Reg. Dist. No.

12840

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Nursing Home		d. STREET ADDRESS 2547 W. Fairmount Ave.	
3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last NEUBAUER		4. DATE OF DEATH Month Dec. Day 29, Year 19 57	
5. SEX Male female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1885
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (rtd)		10b. KIND OF BUSINESS OR INDUSTRY die maker	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Neubauer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA. DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1-2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 0 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from DEC, 24 19 57 , to DEC, 29 19 57 , that I last saw the deceased alive on DEC, 24 19 57 , and that death occurred at 10: A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6348 FREDERICK ROAD. CATONSVILLE BALTIMORE DATE SIGNED 28 MD			
ACTUAL SIGNATURE S. Lloyd Johnson M.D.			
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/1/58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Thm. J. Tiekner & Sons ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR DATE JAN 2 '57	24b. REGISTRAR'S SIGNATURE Dee. Smith

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Sub-Div. 10

NAME OF DECEASED		DATE OF DEATH	
Baldwin, John		Jan 2, 1953	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTHPLACE		NATURALIZATION	
Massachusetts		Naturalized	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		CAUSE OF DEATH	
Retired		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
Physician		Hospital	
John J. Smith		St. Mary's	
DATE OF REPORT		REPORTED BY	
Jan 2, 1953		John J. Smith	

JAN 2 1953

BUREAU V. 1

RECEIVED

12841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b XO Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPTAL						d. STREET ADDRESS 207 S. Woodwell Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Winifred Middle Oberholtzer Last						4. DATE OF DEATH Month Dec. Day 29 Year 19 57					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1893		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James L. THOMAS						14. MOTHER'S MAIDEN NAME Winifred ? NOT KNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records:		Address SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia - Congestive Failure - cystic Malnutrition										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF DEATH Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 12, 1957, to 12-29, 1957, that I last saw the deceased alive on 12-29, 1957, and that death occurred at 11:40 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE C. Eugene Watermann M.D. SPRING GROVE STATE HOSPITAL 12-29-57 PHYSICIAN'S NAME (Type) C. Eugene Watermann Catonsville 28, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal				22b. DATE THEREOF 12/29/57		22c. NAME OF CEMETERY OR CREMATORY WASHBURN ST. CEM.		22d. LOCATION (City, town, or county) (State) SCRANTON PA.			
23. FUNERAL DIRECTOR'S SIGNATURE Address						24a. REC'D BY REGISTRAR DATE 1958		24b. REGISTRAR'S SIGNATURE			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		MALE		35		WHITE		JAN 10 1938		MEMPHIS, TENN.		JAN 30 1968		MEMPHIS, TENN.	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
ATTORNEY AT LAW		SHOOTING		HOMICIDE		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
17. CITY		18. COUNTY		19. STATE		20. ZIP CODE		21. TELEPHONE		22. HOSPITAL		23. FUNERAL HOME		24. BURIAL PLACE	
MEMPHIS		MEMPHIS		TENN.		38101		[Number]		[Name]		[Name]		[Name]	

BUREAU V. 5

JAN 3 1968

RECEIVED

Item 9 Willing 1-7-58 et
12853 CERTIFICATE OF DEATH

1284238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wash</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Mt. Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6072 Falls Road</u>		d. STREET ADDRESS <u>6072 Falls Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary E. Pahl</u>		4. DATE OF DEATH Month Day Year <u>December 27, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Peter Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Helena A. Kluth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Arnold Hust</u>		Address <u>6072 Falls Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of cervix</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1, 1957</u> , to <u>Dec. 28, 1957</u> , that I last saw the deceased alive on <u>Dec. 27, 1957</u> , and that death occurred at <u>5:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Reuben Hoffman</u>		DATE SIGNED <u>12/30/57</u>	
PHYSICIAN'S NAME (Type) <u>REUBEN HOFFMAN</u>		ADDRESS (Street, city or town, state) <u>846 W. 36th St., Baltimore, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Austin E. Donovan</u>		24a. REC'D BY REGISTRAR <u>Michael E. Gray</u>	
ADDRESS <u>3818 Roland Ave</u>		DATE <u>DEC 31 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12854

CERTIFICATE OF DEATH

12843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X0 Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 72 Ritters Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Adam Last Pape		4. DATE OF DEATH Month December Day 5 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Pape		14. MOTHER'S MAIDEN NAME Elizabeth Knell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 13, 19 57 , to Dec. 5, 19 57 , that I last saw the deceased alive on Dec. 5, 19 57 , and that death occurred at 8:30a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12-5-57			
ACTUAL SIGNATURE Stella Wachslor		M.D. SPRING GROVE STATE HOSPITAL 12-5-57	
PHYSICIAN'S NAME (Type) Stella Wachslor, M. D.		Catonsville 28k Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-7-57	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers Home - Pikesville Md.		24a. REC'D BY REGISTRAR DEC 13 57	24b. REGISTRAR'S SIGNATURE W. Beach

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 13 1957

RECEIVED

12855 CERTIFICATE OF DEATH

12844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 3yr9mth11dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 4663 Pimlico Rd.			
3. NAME OF DECEASED (Type or print) First Ida Middle T. Last Paper				4. DATE OF DEATH Month 12- Day 25- Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. ?, 1889	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Muttel Faigenbaum				14. MOTHER'S MAIDEN NAME Schandel Wasselman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month. Day. Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec. 20 , 19 57 , to 12/25 , 19 57 that I last saw the deceased alive on 12/25 , 19 57 , and that death occurred at 10:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12/25/57			
PHYSICIAN'S NAME (Type) STELLA WACHSLER				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-26-57		Rosedale		Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR DATE DEC 27 '57	
						24b. REGISTRAR'S SIGNATURE W. J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12856 CERTIFICATE OF DEATH

12845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 1/2 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 2414 St. Paul Street	
3. NAME OF DECEASED (Type or print) First Grace Middle Wheeler Last Patterson		4. DATE OF DEATH Month December Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1876
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph C. Wheeler		14. MOTHER'S MAIDEN NAME Sophia B. Medinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Dorothy B. Schneider		Address 2414 St. Paul St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 492X DUE TO Bilateral Virus Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 days DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 1 , 19 57 , to Dec. 26 , 19 57 , that I last saw the deceased alive on Dec. 25 , 19 57 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaeffer		ADDRESS (Street, city or town, state) 401 Randon Road Baltimore 29 Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED Dec. 27, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 28, 1957	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DEC 30 '57		24b. REGISTRAR'S SIGNATURE W. Schaeffer	

CERTIFICATE OF DEATH

DATE OF DEATH		BY		PLACE	
JAN 10 1957		J. H. HARRIS		BALTIMORE	
AGE		SEX		RACE	
72		M		W	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JAN 10 1885		BALTIMORE		U.S.A.	
MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE COUNTRY	
JAN 10 1910		BALTIMORE		U.S.A.	
OCCUPATION		EDUCATION		RELIGION	
Carpenter		High School		Roman Catholic	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
Myocardial Infarction		Natural		Home	
DISEASE		SYMPTOMS		TREATMENT	
Coronary Artery Disease		Chest Pain, Shortness of Breath		Medication, Rest	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS HOSPITALIZATION	
Hypertension		None		None	
PREVIOUS DEATH		PREVIOUS MENTAL		PREVIOUS PHYSICAL	
None		None		None	
PREVIOUS INJURY		PREVIOUS TRAUMA		PREVIOUS TOXIC	
None		None		None	
PREVIOUS INFECTION		PREVIOUS ALLERGY		PREVIOUS DRUGS	
None		None		None	
PREVIOUS TUMORS		PREVIOUS BURNS		PREVIOUS FROSTBITE	
None		None		None	
PREVIOUS OTHER		PREVIOUS OTHER		PREVIOUS OTHER	
None		None		None	

RECEIVED
DEC 30 1957
BUREAU W. F.

12857 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>BALTIMORE-COUNTY</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>BALTIMORE</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i> <i>3V01-4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RIDGEWAY MANOR HOME</i>		d. STREET ADDRESS <i>4711 Frederick Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY ELIZABETH PEDDICOORD</i>		4. DATE OF DEATH Month Day Year <i>DEC 24, 1957</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV 17, 1906</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DEPT. STORE</i>	
11. BIRTHPLACE (State or foreign country) <i>BALTO. MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN J. MURPHY</i>		14. MOTHER'S MAIDEN NAME <i>MARY BAKER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>MRS. AGNES M. REITZ</i>		Address <i>4711 Frederick Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Carcinomatosis</i> DUE TO (c) <i>Adenocarcinoma, Cecum</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct. 4</i> 19 <i>57</i> , to <i>Dec. 24</i> 19 <i>57</i> , that I last saw the deceased alive on <i>Dec. 24</i> 19 <i>57</i> , and that death occurred at <i>11:40 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John F. Schaeffer</i> M.D.		ADDRESS (Street, city or town, state) <i>401 Brandon Road Baltimore 29 Md.</i>	
DATE SIGNED <i>Dec. 27, 1957</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 28, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>London Park Cem. Balto.</i>	22d. LOCATION (City, town, or county) (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. Truman Schuch</i>		ADDRESS <i>3512 Frederick Ave. (29)</i>	
24a. REC'D BY REGISTRAR <i>DATE 30 '57</i>		24b. REGISTRAR'S SIGNATURE <i>Rebeccah</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 30 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1284744
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barto.</u> # <u>3 Vol-4</u> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beth Steel Hospital</u>		d. STREET ADDRESS <u>6 N. BOND ST.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MANFIELD</u> First Middle Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Bl.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Hooker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Ship yard</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>ANNIE PERKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs MARY PERKINS</u>		Address <u>6 N. BOND ST</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of SKULL</u> 910.3 DUE TO Let T Fronto-Parietal Area Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fallen Ship Plate Crushed head between Plate + CAR -</u>	
20c. TIME OF INJURY Month <u>—</u> Day <u>6</u> Year <u>1957</u> Hour <u>—</u> p. m. <u>4:00</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Boat Ship yard</u>	20f. (City or town) <u>Sparrows Pt Baltimore Md</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M B Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEM. LYNCHBURG VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ELROY C. WILSON</u>		ADDRESS <u>1000 BRANTLEY AVE</u>	24a. REC'D BY REGISTRAR DATE <u>12/4/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

DEC 10 1957

RECEIVED

12850 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peace in the Inner Sanct.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth J.</u> Middle <u>Carter</u> Last <u>PORTER</u>		DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed & former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Solawatz & Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jacob</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William H. Carter</u>		Address <u>525 Edgewood St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Syphilitic Aortic Atherosclerosis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 10, 1930</u> , to <u>Dec 12, 1957</u> , that I last saw the deceased alive on <u>Dec 11, 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>JAMES W. KATZENBERGER, M.D.</u>		ADDRESS (Street, city or town, state) <u>4123 N. ...</u>	
PHYSICIAN'S NAME (Type) <u>James W. Katzenberger</u>		DATE SIGNED <u>12/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u>		ADDRESS <u>30 Collins St.</u>	
24a. REC'D BY REGISTRAR <u>DEC 16 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES OF AMERICA	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY	
WHITE		WHITE		METHODIST		HIGH SCHOOL		SALES		SUICIDE		SUICIDE		SUICIDE	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		APRIL 4 1968		4:00 PM		4:00		00	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF INTERMENT	
JAMES EARL RAY		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY		SIGNATURE OF INTERMENT	
JAMES EARL RAY		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		THIRD OF DEATH		FOURTH OF DEATH		FIFTH OF DEATH	
APRIL 4 1968		4:00 PM		4:00		00		00		00		00		00	
NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES OF AMERICA	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY	
WHITE		WHITE		METHODIST		HIGH SCHOOL		SALES		SUICIDE		SUICIDE		SUICIDE	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES OF AMERICA		APRIL 4 1968		4:00 PM		4:00		00	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH		NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF INTERMENT	
JAMES EARL RAY		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY		SIGNATURE OF INTERMENT	
JAMES EARL RAY		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS		MEMPHIS	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH		THIRD OF DEATH		FOURTH OF DEATH		FIFTH OF DEATH	
APRIL 4 1968		4:00 PM		4:00		00		00		00		00		00	

BUREAU V. S.

DEC 16 1967

RECEIVED

12728 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4215 Kensington Road</u>				d. STREET ADDRESS <u>4215 Kensington Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William H.</u> Middle <u>Powell</u> Last <u></u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Compositor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Sun Papers</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Josiah Powell</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia Gossnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-2729</u>		17. INFORMANT <u>Mary E. Powell</u> Address <u>4215 Kensington Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Occlusion</u> <u>420.1</u> DUE TO <u>Hypertension arteriosclerotic (C.V. Disease)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Dec 29</u> , 19 <u>57</u> , to <u>Dec 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 29</u> , 19 <u>57</u> , and that death occurred at <u>8:15 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Coalalasan</u> M.D.				ADDRESS (Street, city or town, state) <u>4201 Wilkens Ave - Baltimore, Md</u>			
DATE SIGNED <u>1/1/58</u>							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>1/3/58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Geo M. Trappey</u>			

CERTIFICATE OF DEATH

Name		John Doe	
Residence		123 Main St, Baltimore, Maryland	
Age		45	
Sex		Male	
Race		White	
Occupation		Teacher	
Cause of Death		Heart Disease	
Date of Death		Jan 3, 1923	
Place of Death		Home	
Physician		Dr. J. Smith	
Burial Place		St. Mary's Cemetery	
Burial Date		Jan 5, 1923	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

RECEIVED
JAN 3 1923
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 1 FilmG224 1-3-58 et
12860 CERTIFICATE OF DEATH

12850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex-Bowley's Quarters				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex -- Bowleys Quarters			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 15, Box 722				d. STREET ADDRESS 1 Seneca Road Box 722 Route 15			
3. NAME OF DECEASED (Type or print) First BARBARA Middle JEAN Last PILE				4. DATE OF DEATH Month December Day 24 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 4, 1942	
9. AGE (In years last birthday) 15		IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min. 15		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Listie, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John R. Pyle			
14. MOTHER'S MAIDEN NAME Sarah E. Whitfield				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT John R. Pyle			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcoma of Bone DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) 				20g. (County) 			
20h. (State) 				21. I certify that I attended the deceased from 12-24 , 19 57 , to 12-24 , 19 57 , that I last saw the deceased alive on 12-24-57 , 19 57 , and that death occurred at 1:05 P.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) University Hospital				DATE SIGNED DEC 30 1957			
ACTUAL SIGNATURE Marion A. Goldstein				M.D. (University Hospital)			
PHYSICIAN'S NAME (Type) 				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Dec. 27, 1957				22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.			
22d. LOCATION (City, town, or county) Baltimore County, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.			
ADDRESS 1217 St. Paul Street				24a. REC'D BY REGISTRAR DEC 30 1957			
24b. REGISTRAR'S SIGNATURE 				24c. REGISTRAR'S SIGNATURE 			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. SMITH		2. SEX Male		3. AGE 45	
4. DATE OF DEATH January 15, 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF DECEASED [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF REGISTRAR [Signature]	

BUREAU V. S.

EC 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12861 CERTIFICATE OF DEATH

12851 *ds*

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>318 Miles Road #21</u>				d. STREET ADDRESS <u>318 Miles Road #21</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Godwin</u> Last <u>Quillin</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 2, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Quillin</u>				14. MOTHER'S MAIDEN NAME <u>MARY GODWIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-03-0805</u>		17. INFORMANT <u>Mrs. Stella C. Quillin</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Residual hemorrhage</u> <u>199.9</u> DUE TO <u>metastatic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary site undetermined</u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 - 125</u> <u>6 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u>				DATE SIGNED <u>12/15/57</u>			
ACTUAL SIGNATURE <u>J. PLATT, M.D.</u>				M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u>J. PLATT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Platt</u>				1407 ADDRESS <u>Eastern Ave.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>				DATE <u>DEC 20</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

DEC 20 1957

RECEIVED

12862 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u> 52			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Conv Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY NELLIE RAPPANIER</u>				4. DATE OF DEATH <u>12/8/57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Kriete</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Bergner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Laura Kriete</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u></u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u></u> 19 <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>2 September, 19 57</u> to <u>8 December, 19 57</u> , that I last saw the deceased alive on <u>8 December, 19 57</u> , and that death occurred at <u>10:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Millard T. Traband, Jr.</u>				ADDRESS (Street, city or town, state) <u>5101 Gwynn Oak Ave. Balt. 7, Md.</u> DATE SIGNED <u>12/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr. M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) <u>Balto. Co. Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McNabb & Son</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>DEC 11 57</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

11

239

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12869 CERTIFICATE OF DEATH

1285378

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Towson				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood - Towson 4, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2324 Hopkins Rd. Rogu-Faye			
				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUISE Middle MARGRET Last TRAYSINGER				4. DATE OF DEATH Month 12 Day 21 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3/31/09	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 4 Days 21 Hours 19 Min.		IF UNDER 24 HRS. Months 4 Days 21 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal Secretary				10b. KIND OF BUSINESS OR INDUSTRY Balto Md		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John Wm Raysinger				14. MOTHER'S MAIDEN NAME Rita Stein			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] 213-05-6857				17. INFORMANT Personal History Address Hospital Records, Eudowood Sanatorium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix - Inoperable 171X DUE TO with metastases to adnexa + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adnexa DUE TO (c) adnexa				INTERVAL BETWEEN ONSET AND DEATH 2 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-16 , 19 57 to 12-21 , 19 57 , that I last saw the deceased alive on 12-20 , 19 57 , and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eudowood Sanatorium DATE SIGNED Milton B. Kress							
ACTUAL SIGNATURE Milton B. Kress M.D.							
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.				Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-24-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Kuck				ADDRESS 1305 Naylor		24a. REC'D BY REGISTRAR DEC 24 1957	
				24b. REGISTRAR'S SIGNATURE Mabel Grays			

BUREAU V. 5

DEC 24 1957

RECEIVED

12864 CERTIFICATE OF DEATH

12854

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nurs. Ho.-100 N.Rolling Rd		d. STREET ADDRESS 5006 Edmondson Ave.	
3. NAME OF DECEASED (Type or print) First CARL Middle REINHARDT Last		4. DATE OF DEATH Month Dec. Day 8 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1901
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed-Operator		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles W. Reinhardt		14. MOTHER'S MAIDEN NAME Charlotte Weber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Mrs. Freda Reinhardt - 5006 Edmondson Ave.	
17. INFORMANT Mrs. Freda Reinhardt - 5006 Edmondson Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis - 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive pneumonia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 weeks 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1957 , to Dec 8, 1957 , that I last saw the deceased alive on Dec 8, 1957 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2604 Garrison Blvd. DATE SIGNED " "			
ACTUAL SIGNATURE Howard H. Warner M.D.		PHYSICIAN'S NAME (Type) HOWARD H. WARNER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/57	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Tiekner & Sons - Balto 17, Md		24a. REC'D BY REGISTRAR DATE 12/10/57	24b. REGISTRAR'S SIGNATURE R. H. Hedrick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12865

CERTIFICATE OF DEATH

12855

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 14 Eastern Blvd.</u>		d. STREET ADDRESS <u>Box 14 Eastern Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Reinhardt</u>		4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1869</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baliff-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Reinhardt</u>		14. MOTHER'S MAIDEN NAME <u>Kate Haas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Christina League</u>		Address <u>Box 14 Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 14</u> , 19 <u>57</u> , to <u>Dec 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 11</u> , 19 <u>57</u> , and that death occurred at <u>6:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James White</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>422 Eastern Ave. Baltimore 24201 12/11/57</u>	
PHYSICIAN'S NAME (Type) <u>James White</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 11, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sparks Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>DECEMBER 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Lawson L. Farber</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1880		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
Carpenter		Heart Disease		Natural		10 days		1925		BALTIMORE		MD		USA	
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE	
High School		Roman Catholic		Married		1905		BALTIMORE		MD		BALTIMORE		MD	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE OF BIRTH		MOTHER'S STATE OF BIRTH	
John H. Harris		Mary E. Harris		Carpenter		Homemaker		BALTIMORE		BALTIMORE		MD		MD	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE OF DEATH		MOTHER'S STATE OF DEATH		FATHER'S COUNTRY OF DEATH		MOTHER'S COUNTRY OF DEATH	
1880		1885		BALTIMORE		BALTIMORE		MD		MD		USA		USA	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PERIOD OF ILLNESS		MOTHER'S PERIOD OF ILLNESS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
Heart Disease		Heart Disease		Natural		Natural		10 days		10 days		1925		1925	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE OF DEATH		MOTHER'S STATE OF DEATH		FATHER'S COUNTRY OF DEATH		MOTHER'S COUNTRY OF DEATH	
1925		1925		BALTIMORE		BALTIMORE		MD		MD		USA		USA	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PERIOD OF ILLNESS		MOTHER'S PERIOD OF ILLNESS		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
Heart Disease		Heart Disease		Natural		Natural		10 days		10 days		1925		1925	

RECEIVED
DEC 13 1925
BUREAU V. S.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b <i>x 2</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1749 Forrest Avenue</i>		d. STREET ADDRESS <i>1749 Forrest Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mrs.</i> Middle <i>Della C.</i> Last <i>Revis</i>		4. DATE OF DEATH Month <i>December</i> Day <i>27th</i> Year <i>19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 22, 1879</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Asheville, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Wheeler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Banks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Oliver D. Revis, 1749 Forrest Ave/</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>myocardial failure</i> (b) <i>2</i> <i>hypertension</i> (c) <i>3</i> <i>generalized arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5-10 yrs</i> <i>5-10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 15, 1949</i> to <i>Dec 27, 1957</i> , that I last saw the deceased alive on <i>Dec 27, 1957</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>3009 EVERGREEN AVE BALTO 14 MD</i>	
ACTUAL SIGNATURE <i>Donald W. Mintzer</i> M.D.		DATE SIGNED <i>12/27/57</i>	
PHYSICIAN'S NAME (Type) <i>Donald W. Mintzer</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/30/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road.</i>		24a. REC'D BY REGISTRAR <i>DEC 30 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Bill M. Larson</i>	

BUREAU V. S.

DEC 30 1957

RECEIVED

12867

CERTIFICATE OF DEATH

12857

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 353 Rosebank Avenue			
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last RHODES				4. DATE OF DEATH Month December Day 20 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/26/89	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Man		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Willis Rhodes				14. MOTHER'S MAIDEN NAME Mazie Moorehead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-12-1359		17. INFORMANT Clin.Rec.Div.Vets.Admin.Hospital,Ft.Howard,Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOMEGALY WITH HYPERTROPHY OF LEFT AND RIGHT VENTRICLES. DUE TO ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIAC VASCULAR AND RENAL DISEASES. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown. Unknown.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from December 14, 19 57 , to December 20, 19 57 , and that death occurred at 11:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Fort Howard, Maryland DATE SIGNED 12/21/57 ACTUAL SIGNATURE Chien Wei-Lan PHYSICIAN'S NAME (Type) Chien Wei LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National.		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave., Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				24a. REC'D BY REGISTRAR DATE 12/27/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

Wm Cook-Blight Funeral Home 6009 Harford Road, Balto. 14, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		DATE OF DEATH 12-25-1957	
PLACE OF DEATH Home		AGE 65 years	
RESIDENCE 123 Main Street, Baltimore, Md.		OCCUPATION Teacher	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. Smith		SIGNATURE OF DECEASED John Doe	
DATE OF SIGNATURE 12-25-1957		DATE OF SIGNATURE 12-25-1957	

RECEIVED
DEC 30 1957
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12868 CERTIFICATE OF DEATH

12858 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN IB <u>40 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>201 1st Street</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>F.</u> Last <u>RITTMAYER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1882</u>
9. AGE (In years last birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Police Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pajern, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Rittmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Dora Shick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>220-24-6739</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE STOMACH</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 24</u> , 19 <u>57</u> , to <u>December 3</u> , 19 <u>57</u> , that the deceased died of <u>CAUSE OF DEATH</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irving Freeman</u> M.D.		ADDRESS (Street, city or town, state) <u>VAH Ft. Howard, Md</u> DATE SIGNED <u>12/3/57</u>	
PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D.,</u>		<u>VAH Ft. Howard, Md</u> <u>12/3/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Hghwy, Balto. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Skirley</u>		ADDRESS <u>Hopping & Kirkley, 421 Crain Hghwy, Glen Burnie Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jawson L Farber</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

DEC 6 1957

RECEIVED

. 12869 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 55yr6mth7dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3101.4			
d. STREET ADDRESS 2306 Mt. Royal Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Esther Middle Rogers Last Rogers				4. DATE OF DEATH Month December Day 31 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARITAL STATUS WIDOWED	8. DATE OF BIRTH Sept. 25, 1874		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia ✓	
13. FATHER'S NAME Morris Kenefsky				14. MOTHER'S MAIDEN NAME Catherine Lechinsky			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 24 , 19 57 , to Dec. 31 , 19 57 , that I last saw the deceased alive on Dec. 31 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 12-31-57					
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/58		22c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lechner & Sons				ADDRESS 11800		24a. REC'D BY REGISTRAR DATE 1/2/58	
				24b. REGISTRAR'S SIGNATURE R. H. Lechner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the deceased. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12860
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 97
12870										
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford c. LENGTH OF STAY IN 1b Hereford d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Monkton Road					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford d. STREET ADDRESS Monkton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First FRANCES Middle MARIE Last RUHL					4. DATE OF DEATH Month December Day 9 Year 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1909		9. AGE (In years last birthday) 48 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joshua Talbott Kelley					14. MOTHER'S MAIDEN NAME Mae Colgate					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Preston Ruhl, Monkton Rd., Hereford, Md. Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute extensive esophagitis and gastritis DUE TO 9771.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ingestion of pine oil deodorant compound DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingestion of pine oil deodorant compound								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12/9 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Baltimore (County) (State) Md.				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE P. R. F. Ruhl		EXAMINER'S NAME (Type) P. R. F. Ruhl		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/9/57				
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1957		22c. NAME OF CEMETERY OR CREMATORY May's Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Timonium, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Lono		ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DEC 12 1957		24b. REGISTRAR'S SIGNATURE John Lono				

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Last Name		First Name		Middle Name		Initials	
Date of Birth		Place of Birth		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation		Education	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness	
Date of Examination		Time of Examination		Location of Examination		Remarks	

BUREAU V. B.

DEC 12 1957

RECEIVED

12871 CERTIFICATE OF DEATH

12861

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMIL Middle --- Last SAAL		4. DATE OF DEATH Month December Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1874
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant- Retired		10b. KIND OF BUSINESS OR INDUSTRY Grocery Business	
11. BIRTHPLACE (State or foreign country) Panora, Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Doyasal Saal		14. MOTHER'S MAIDEN NAME Margaret Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) SAW		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Address Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE OF ANEURYSM OF THE ABDOMINAL AORTA DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 451x DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 16, 1957 to December 17, 1957 and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Chien Wei Lan		ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 12/18/57	
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-18-57	22c. NAME OF CEMETERY OR CREMATORY Tarkio Cemetery	22d. LOCATION (City, town, or county) (State) Tarkio, Missouri
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Baltimore 14, Md.		24a. REC'D BY REGISTRAR 12/27/57 24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 18 Film 224 1-6-58 ans											
12722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 12862 41											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 92 Dundalk Avenue					d. STREET ADDRESS 92 Dundalk Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDITH Middle L Last SAFLEY					4. DATE OF DEATH Month December Day 10 Year 19 57						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 25, '12		9. AGE (In years last birthday) 44 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Bar Room		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME Edward Dough					14. MOTHER'S MAIDEN NAME Willie Groome						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none			16. SOCIAL SECURITY NO.		17. INFORMANT Chas. F. Safley Sr. 92 Dundalk Ave						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 355.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Paul F. Guerin						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 12/10/57		
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-13-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest			22d. LOCATION (City, town, or county) (State) Louisa, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard						ADDRESS 4107 Wilkens Ave		24a. REC'D BY REGISTRAR DEC 12 1957		24b. REGISTRAR'S SIGNATURE Mr. Kelly	

RECEIVED

DEC 12 1957

BUREAU V. S.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)		c. LENGTH OF STAY IN 1b Baltimore (13)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 185 Squehanna Avenue						d. STREET ADDRESS 3042 21st Mayfield Avenue					
3. NAME OF DECEASED (Type or print) ROSE		First ANNA		Last SCHLAUCH		4. DATE OF DEATH December 30 1957		Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1914		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Lisy						14. MOTHER'S MAIDEN NAME Marie Anna Sykora					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Sebastian C. Schlauch, husband, above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490x Lobar pneumonia, left lower lobe											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell in water while in confused state due to pneumonia							
20c. TIME OF INJURY Month, Day, Year 4:30 p. m. 12/30 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water		20f. (City or town) Baltimore		(County) (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher, M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12/31/57			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane						24c. REC'D BY REGISTRAR DATE JAN 3 1958		24b. REGISTRAR'S SIGNATURE Edith Purley			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 3 1933

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1933

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF EXAMINER: [illegible]

12873 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN TB 7 mos. 15 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN		x1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE ST. HOSP.		d. STREET ADDRESS WINDSOR MILL RD.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SCHMIER Last SCHMIER		4. DATE OF DEATH Month 12 Day 8 Year 1957	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm helper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY SCHMIER		14. MOTHER'S MAIDEN NAME CAROLINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MRS. FRED. C. TYSON		Address 4710 HADDON AVE BALT.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of Myocardium 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Thrombosis DUE TO (c) Arteriosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/23/57 19 to 12/8/57 19, that I last saw the deceased alive on 12/8/57 19, and that death occurred at 1:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas		ADDRESS (Street, city or town, state) Spring Grove St. Hospital	
PHYSICIAN'S NAME (Type) Bruno RADAUSKAS		DATE SIGNED 12/8/1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-10-57	22c. NAME OF CEMETERY OR CREMATORY BALTIMORE
22d. LOCATION (City, town, or county) BALTO.		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. STANSBURY		ADDRESS 6411 Windsor Mill	
24a. REC'D BY REGISTRAR DEC 11 '57		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 11 1957

RECEIVED

12874 CERTIFICATE OF DEATH

12865

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol - 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Augsburg Home - 6811 Campfield Rd.				d. STREET ADDRESS 2117 Belair Rd.			
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last SCHMITT				4. DATE OF DEATH Month Dec. Day 13, Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l. Agt. (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Ald Asso. for Lutherans		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry C. Schmitt				14. MOTHER'S MAIDEN NAME Amelia R. Weyrich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Lillian Koletschke - 1636 Northgate Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x (1) - Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 21 Broncho - Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x - Generalized Arterio - Sclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 days 24 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from June - 1957 , to Dec. 13, 1957 , that I last saw the deceased alive on Dec. 12 - 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Earl L. Chambers		M.D. 4108 Liberty Hts. - Balto - Md - 12-13-57		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) Earl L. Chambers -		4108 Liberty Hts. Ave - Balto - Md - 12-13-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/16/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) Woodlawn, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichner & Sons - Balto 17th		ADDRESS		24a. REC'D BY REGISTRAR DATE 12/16/57	24b. REGISTRAR'S SIGNATURE Joseph Bewell		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

REG. DIST. NO.

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		DISEASE OR INJURY	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		PREVIOUS ILLNESS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PATHOLOGICAL FINDINGS		LABORATORY FINDINGS	
POST-MORTEM EXAMINATION		SIGNATURE OF PHYSICIAN	
SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	

BUREAU V. 2

DEC 17 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M-1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

12866

Reg. Dist. No.

12875

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE 3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines 16 MUSTING AVE</u>				STREET ADDRESS (If rural give location) <u>120 S. CALHOUN ST.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>CHARLES C.</u> (Middle) <u>SCHREINER</u> (Last)				4. DATE OF DEATH (Month) <u>DEC.</u> (Day) <u>9</u> (Year) <u>19 57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 7, 1886</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXTERMINATOR PEST CONTROL</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>PEST CONTROL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>CHARLES SCHREINER</u>				14. MOTHER'S MAIDEN NAME <u>CHARA E. SCHEAFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WORLD WAR I 212-20-7209</u>		17. INFORMANT & ADDRESS <u>MAMIE SMITH 2118 W BALTO. ST.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) <u>Broncho-Pneumonia</u>						<u>2 da.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Epidermoid Carcinoma, Left Side of Tongue</u>						<u>6 mo.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-3</u> , 19 <u>57</u> , to <u>12-9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-9</u> , 19 <u>57</u> , and that death occurred at <u>11:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Wilmer K. Gallagher</u>		DATE THEREOF <u>12-12-57</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>DEC 12 '57</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u>		ADDRESS <u>2101 Frederick Ave.</u>	

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6637 Frederick Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Schroeder</u> Last <u>Schroeder</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1874</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u> </u>		13. FATHER'S NAME <u>Fred. Von Lindenberg</u>	
14. MOTHER'S MAIDEN NAME <u>Not Known</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Murray Harrison</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arterio Sclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.?</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1957</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>Sept. 1, 1957</u> to <u>Dec. 29, 1957</u> , that I last saw the deceased alive on <u>Dec. 26, 1957</u> , and that death occurred at <u>30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1905 W. Beltsville Rd. Balt. Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Daniel E. Bogorad</u> M.D.		PHYSICIAN'S NAME (Type) <u>DANIEL E. BOGORAD M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-31-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn XXX Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Keep Over 100

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF WITNESSES
13. SIGNATURE OF DECEASED
14. SIGNATURE OF NEXT OF KIN
15. SIGNATURE OF CLERGYMAN
16. SIGNATURE OF MINISTER
17. SIGNATURE OF CHURCH
18. SIGNATURE OF FUNERAL HOME
19. SIGNATURE OF BURIAL PLACE
20. SIGNATURE OF INTERMENT PLACE
21. SIGNATURE OF INTERMENT PLACE
22. SIGNATURE OF INTERMENT PLACE
23. SIGNATURE OF INTERMENT PLACE
24. SIGNATURE OF INTERMENT PLACE
25. SIGNATURE OF INTERMENT PLACE
26. SIGNATURE OF INTERMENT PLACE
27. SIGNATURE OF INTERMENT PLACE
28. SIGNATURE OF INTERMENT PLACE
29. SIGNATURE OF INTERMENT PLACE
30. SIGNATURE OF INTERMENT PLACE

BUREAU V. S.

JAN 3 1906

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for X-ray files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12868
Reg. Dist. No.

38

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 55 TOWSON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 234 E. SUSQUEHANNA AVE		d. STREET ADDRESS 234 E. SUSQUEHANNA	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle R. Last SCHROEDER		4. DATE OF DEATH Month DEC Day 30 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 1, 1916
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 4 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE		10b. KIND OF BUSINESS OR INDUSTRY NY	
11. BIRTHPLACE (State or foreign country) NY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN CLEVE		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT KENNETH (Husband)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT LOWER DUE TO 490X Conditions, if any, which gave rise to immediate cause (b) 490X (c) 490X DUE TO 490X cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William A. Pillsbury M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons		ADDRESS Towson, Md.	
24a. REC'D BY REGISTRAR JAN 2 1958		24b. REGISTRAR'S SIGNATURE Nabel Gray	

MEDICAL CERTIFICATION

2

BUREAU V. S.

JAN 2 1958

RECEIVED

12878

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 354 Silver Spring Rd.</u>		d. STREET ADDRESS <u>Box 354 Silver Spring Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Schultz</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> , Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wendell Schultz</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Slater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 1 316-34-8774</u>	
17. INFORMANT <u>Mrs. Rosa E. Schultz</u>		Address <u>Box 354 Silver Spring Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive Heart Failure</u> (b) <u>Coronary Sclerotic Heart Dis</u> DUE TO <u>10 yrs.</u> (c) <u>8 Mbs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 Mbs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/19</u> , 19 <u>57</u> , to <u>12/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>57</u> , and that death occurred at <u>5:13 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		DATE SIGNED <u>FORK, MD.</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>		<u>FORK, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 2, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>	22d. LOCATION (City, town, or county) (State) <u>Fullerton Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>JAN 2 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12879

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G223 12-30-57 et

12870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11mth5dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro Washington 27, 16 x 1.2	
3. NAME OF DECEASED (Type or print) First Susan Middle Elizabeth Last Sherman		4. DATE OF DEATH Month December Day 10 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1887
9. AGE (in years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown WALTER TUCKER		14. MOTHER'S MAIDEN NAME Unknown MARGARET CROSBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown NONE	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 9047 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) fracture left femur accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) operation for fracture sigmoid prior INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was pushed down by another patient on 8-19-57, sustaining an intertrochanteric fracture of left femur	
20c. TIME OF INJURY Month, Day, Year Hour 4:30 P. M. 8-19 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-11-57	
22a. BURIAL, CREMATION, or OTHER DISPOSAL (Specify) BURIAL		22b. DATE THEREOF 12-14-1957	
22c. NAME OF CEMETERY OR CREMATORY Friendship Methodist Church Friendship Md.		22d. LOCATION (City, town, or county) (State) md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR DEC 16 57	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. W. Chambers	

INVESTIGATION OF DEATH - BUREAU OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
WALTER T. WILSON		47		Male		White		12-16-1957		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASES PREEXISTING		DISEASES PRESENT	
1234 Main St., New York, N.Y.		Engineer		Heart Disease		Natural		Hypertension, Atherosclerosis		Pneumonia	
FATHER		MOTHER		SPOUSE		CHILDREN		SIBLINGS		OTHER RELATIVES	
John T. Wilson		Mary T. Wilson		Elizabeth T. Wilson		Robert T. Wilson		William T. Wilson		Margaret T. Wilson	
DECEASED'S SIGNATURE		MEDICAL EXAMINER'S SIGNATURE		MEDICAL EXAMINER'S NAME		MEDICAL EXAMINER'S ADDRESS		MEDICAL EXAMINER'S PHONE		MEDICAL EXAMINER'S LICENSE NO.	
[Signature]		[Signature]		Dr. J. H. Smith		1234 Main St., New York, N.Y.		(212) 123-4567		12345	

BUREAU V. S.

DEC 16 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer Park Road</u>		d. STREET ADDRESS <u>1 Deer Park Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE ANN SHIPLEY</u>		4. DATE OF DEATH Month Day Year <u>December 23 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1867</u> 9. AGE (In years last birthday) <u>90</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Spob</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ann Frederick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Ann Murray, Deer Park Rd Reisterstown Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 hours</u> <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December 17, 1957</u> , to <u>December 23 1957</u> , that I last saw the deceased alive on <u>December 23 1957</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. McWilliams</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>Dec 23 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 26-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Reisterstown Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Berryman & Sons</u> ADDRESS <u>Reisterstown</u>		24a. REC'D BY REGISTRAR <u>DATE 12-26-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary B. Elmer</u>

BUREAU V. S.

DEC 30 1957

RECEIVED

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

CERTIFICATE OF DEATH

12872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Convalescent Home</u>				d. STREET ADDRESS <u>5501 Ashbourne Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>James</u> Middle <u>D.</u> Last <u>Sigler</u>		4. DATE OF DEATH		Month <u>December</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/1891</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James D. Sigler</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary E. O'Leary - 1521 Arbutus Avenue</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Renal insufficiency</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>imo</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Malacia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>12</u> <u>21</u> <u>1957</u> p. m. <u> </u> <u> </u> <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Catonsville</u>		20f. (City or town) (County) (State) <u>Bethesda</u> <u>Ind</u>	
21. I certify that I attended the deceased from <u>Dec 20</u> , 19 <u>57</u> , to <u>Dec 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Tommasello</u> M.D.				ADDRESS (Street, city or town, state) <u>910 W. Lombard</u> DATE SIGNED <u>Dec 22/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Tommasello MD</u>				<u>910 W. Lombard St. Baltimore Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George P. Weber Jr.</u>				ADDRESS <u>5713 First Ave. - 27</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 57</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CHURCH</p>	
<p>19. SIGNATURE OF CEMETERY</p>		<p>20. SIGNATURE OF INTERVIEWER</p>	
<p>21. SIGNATURE OF INTERVIEWER</p>		<p>22. SIGNATURE OF INTERVIEWER</p>	
<p>23. SIGNATURE OF INTERVIEWER</p>		<p>24. SIGNATURE OF INTERVIEWER</p>	
<p>25. SIGNATURE OF INTERVIEWER</p>		<p>26. SIGNATURE OF INTERVIEWER</p>	
<p>27. SIGNATURE OF INTERVIEWER</p>		<p>28. SIGNATURE OF INTERVIEWER</p>	
<p>29. SIGNATURE OF INTERVIEWER</p>		<p>30. SIGNATURE OF INTERVIEWER</p>	
<p>31. SIGNATURE OF INTERVIEWER</p>		<p>32. SIGNATURE OF INTERVIEWER</p>	
<p>33. SIGNATURE OF INTERVIEWER</p>		<p>34. SIGNATURE OF INTERVIEWER</p>	
<p>35. SIGNATURE OF INTERVIEWER</p>		<p>36. SIGNATURE OF INTERVIEWER</p>	
<p>37. SIGNATURE OF INTERVIEWER</p>		<p>38. SIGNATURE OF INTERVIEWER</p>	
<p>39. SIGNATURE OF INTERVIEWER</p>		<p>40. SIGNATURE OF INTERVIEWER</p>	
<p>41. SIGNATURE OF INTERVIEWER</p>		<p>42. SIGNATURE OF INTERVIEWER</p>	
<p>43. SIGNATURE OF INTERVIEWER</p>		<p>44. SIGNATURE OF INTERVIEWER</p>	
<p>45. SIGNATURE OF INTERVIEWER</p>		<p>46. SIGNATURE OF INTERVIEWER</p>	
<p>47. SIGNATURE OF INTERVIEWER</p>		<p>48. SIGNATURE OF INTERVIEWER</p>	
<p>49. SIGNATURE OF INTERVIEWER</p>		<p>50. SIGNATURE OF INTERVIEWER</p>	
<p>51. SIGNATURE OF INTERVIEWER</p>		<p>52. SIGNATURE OF INTERVIEWER</p>	
<p>53. SIGNATURE OF INTERVIEWER</p>		<p>54. SIGNATURE OF INTERVIEWER</p>	
<p>55. SIGNATURE OF INTERVIEWER</p>		<p>56. SIGNATURE OF INTERVIEWER</p>	
<p>57. SIGNATURE OF INTERVIEWER</p>		<p>58. SIGNATURE OF INTERVIEWER</p>	
<p>59. SIGNATURE OF INTERVIEWER</p>		<p>60. SIGNATURE OF INTERVIEWER</p>	
<p>61. SIGNATURE OF INTERVIEWER</p>		<p>62. SIGNATURE OF INTERVIEWER</p>	
<p>63. SIGNATURE OF INTERVIEWER</p>		<p>64. SIGNATURE OF INTERVIEWER</p>	
<p>65. SIGNATURE OF INTERVIEWER</p>		<p>66. SIGNATURE OF INTERVIEWER</p>	
<p>67. SIGNATURE OF INTERVIEWER</p>		<p>68. SIGNATURE OF INTERVIEWER</p>	
<p>69. SIGNATURE OF INTERVIEWER</p>		<p>70. SIGNATURE OF INTERVIEWER</p>	
<p>71. SIGNATURE OF INTERVIEWER</p>		<p>72. SIGNATURE OF INTERVIEWER</p>	
<p>73. SIGNATURE OF INTERVIEWER</p>		<p>74. SIGNATURE OF INTERVIEWER</p>	
<p>75. SIGNATURE OF INTERVIEWER</p>		<p>76. SIGNATURE OF INTERVIEWER</p>	
<p>77. SIGNATURE OF INTERVIEWER</p>		<p>78. SIGNATURE OF INTERVIEWER</p>	
<p>79. SIGNATURE OF INTERVIEWER</p>		<p>80. SIGNATURE OF INTERVIEWER</p>	
<p>81. SIGNATURE OF INTERVIEWER</p>		<p>82. SIGNATURE OF INTERVIEWER</p>	
<p>83. SIGNATURE OF INTERVIEWER</p>		<p>84. SIGNATURE OF INTERVIEWER</p>	
<p>85. SIGNATURE OF INTERVIEWER</p>		<p>86. SIGNATURE OF INTERVIEWER</p>	
<p>87. SIGNATURE OF INTERVIEWER</p>		<p>88. SIGNATURE OF INTERVIEWER</p>	
<p>89. SIGNATURE OF INTERVIEWER</p>		<p>90. SIGNATURE OF INTERVIEWER</p>	
<p>91. SIGNATURE OF INTERVIEWER</p>		<p>92. SIGNATURE OF INTERVIEWER</p>	
<p>93. SIGNATURE OF INTERVIEWER</p>		<p>94. SIGNATURE OF INTERVIEWER</p>	
<p>95. SIGNATURE OF INTERVIEWER</p>		<p>96. SIGNATURE OF INTERVIEWER</p>	
<p>97. SIGNATURE OF INTERVIEWER</p>		<p>98. SIGNATURE OF INTERVIEWER</p>	
<p>99. SIGNATURE OF INTERVIEWER</p>		<p>100. SIGNATURE OF INTERVIEWER</p>	

BUREAU V. S.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12882 CERTIFICATE OF DEATH

12873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 12900 Hillcrest Av.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle B. Last SISSON				4. DATE OF DEATH Month 12 / Day 16 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/1869		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LOUIS Sisson				14. MOTHER'S MAIDEN NAME Willie Webb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-07-53484		17. INFORMANT Hospital Record.		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) many years						INTERVAL BETWEEN ONSET AND DEATH probably several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 19, 1957 , to Dec 16, 1957 , that I last saw the deceased alive on Dec 16, 1957 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hosp. Catonsville 28 Md DATE SIGNED 12/16/57							
ACTUAL SIGNATURE Bruno Radauskas				PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/57		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Road #14		24a. REC'D BY REGISTRAR DATE DEC 20 '57	
				24b. REGISTRAR'S SIGNATURE W. J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 20 1957

BUREAU V. S.

1. NAME OF DECEASED [illegible]		2. SEX [illegible]	
3. AGE [illegible]		4. DATE OF BIRTH [illegible]	
5. PLACE OF BIRTH [illegible]		6. OCCUPATION [illegible]	
7. MARITAL STATUS [illegible]		8. EDUCATION [illegible]	
9. RELIGION [illegible]		10. RACE [illegible]	
11. SOCIAL SECURITY NUMBER [illegible]		12. DATE OF DEATH [illegible]	
13. PLACE OF DEATH [illegible]		14. CAUSE OF DEATH [illegible]	
15. MANNER OF DEATH [illegible]		16. SIGNATURE OF DECEASED [illegible]	
17. SIGNATURE OF WITNESS [illegible]		18. SIGNATURE OF DECEASED [illegible]	
19. SIGNATURE OF WITNESS [illegible]		20. SIGNATURE OF DECEASED [illegible]	
21. SIGNATURE OF WITNESS [illegible]		22. SIGNATURE OF DECEASED [illegible]	
23. SIGNATURE OF WITNESS [illegible]		24. SIGNATURE OF DECEASED [illegible]	
25. SIGNATURE OF WITNESS [illegible]		26. SIGNATURE OF DECEASED [illegible]	
27. SIGNATURE OF WITNESS [illegible]		28. SIGNATURE OF DECEASED [illegible]	
29. SIGNATURE OF WITNESS [illegible]		30. SIGNATURE OF DECEASED [illegible]	
31. SIGNATURE OF WITNESS [illegible]		32. SIGNATURE OF DECEASED [illegible]	
33. SIGNATURE OF WITNESS [illegible]		34. SIGNATURE OF DECEASED [illegible]	
35. SIGNATURE OF WITNESS [illegible]		36. SIGNATURE OF DECEASED [illegible]	
37. SIGNATURE OF WITNESS [illegible]		38. SIGNATURE OF DECEASED [illegible]	
39. SIGNATURE OF WITNESS [illegible]		40. SIGNATURE OF DECEASED [illegible]	
41. SIGNATURE OF WITNESS [illegible]		42. SIGNATURE OF DECEASED [illegible]	
43. SIGNATURE OF WITNESS [illegible]		44. SIGNATURE OF DECEASED [illegible]	
45. SIGNATURE OF WITNESS [illegible]		46. SIGNATURE OF DECEASED [illegible]	
47. SIGNATURE OF WITNESS [illegible]		48. SIGNATURE OF DECEASED [illegible]	
49. SIGNATURE OF WITNESS [illegible]		50. SIGNATURE OF DECEASED [illegible]	
51. SIGNATURE OF WITNESS [illegible]		52. SIGNATURE OF DECEASED [illegible]	
53. SIGNATURE OF WITNESS [illegible]		54. SIGNATURE OF DECEASED [illegible]	
55. SIGNATURE OF WITNESS [illegible]		56. SIGNATURE OF DECEASED [illegible]	
57. SIGNATURE OF WITNESS [illegible]		58. SIGNATURE OF DECEASED [illegible]	
59. SIGNATURE OF WITNESS [illegible]		60. SIGNATURE OF DECEASED [illegible]	
61. SIGNATURE OF WITNESS [illegible]		62. SIGNATURE OF DECEASED [illegible]	
63. SIGNATURE OF WITNESS [illegible]		64. SIGNATURE OF DECEASED [illegible]	
65. SIGNATURE OF WITNESS [illegible]		66. SIGNATURE OF DECEASED [illegible]	
67. SIGNATURE OF WITNESS [illegible]		68. SIGNATURE OF DECEASED [illegible]	
69. SIGNATURE OF WITNESS [illegible]		70. SIGNATURE OF DECEASED [illegible]	
71. SIGNATURE OF WITNESS [illegible]		72. SIGNATURE OF DECEASED [illegible]	
73. SIGNATURE OF WITNESS [illegible]		74. SIGNATURE OF DECEASED [illegible]	
75. SIGNATURE OF WITNESS [illegible]		76. SIGNATURE OF DECEASED [illegible]	
77. SIGNATURE OF WITNESS [illegible]		78. SIGNATURE OF DECEASED [illegible]	
79. SIGNATURE OF WITNESS [illegible]		80. SIGNATURE OF DECEASED [illegible]	
81. SIGNATURE OF WITNESS [illegible]		82. SIGNATURE OF DECEASED [illegible]	
83. SIGNATURE OF WITNESS [illegible]		84. SIGNATURE OF DECEASED [illegible]	
85. SIGNATURE OF WITNESS [illegible]		86. SIGNATURE OF DECEASED [illegible]	
87. SIGNATURE OF WITNESS [illegible]		88. SIGNATURE OF DECEASED [illegible]	
89. SIGNATURE OF WITNESS [illegible]		90. SIGNATURE OF DECEASED [illegible]	
91. SIGNATURE OF WITNESS [illegible]		92. SIGNATURE OF DECEASED [illegible]	
93. SIGNATURE OF WITNESS [illegible]		94. SIGNATURE OF DECEASED [illegible]	
95. SIGNATURE OF WITNESS [illegible]		96. SIGNATURE OF DECEASED [illegible]	
97. SIGNATURE OF WITNESS [illegible]		98. SIGNATURE OF DECEASED [illegible]	
99. SIGNATURE OF WITNESS [illegible]		100. SIGNATURE OF DECEASED [illegible]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

12883

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS		c. LENGTH OF STAY IN 1b 5mo 15days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STEVEN HAROLD SMITH		4. DATE OF DEATH Dec 28 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20, 1948
9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Hamman Smith		14. MOTHER'S MAIDEN NAME Mary Jane Langford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT Parents -		Address 502 Zuckerman Ave Fort Benning, Georgia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia - bilat 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Palsy and Epilepsy DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-13 , 19 57 , to 12-28 , 19 57 , that I last saw the deceased alive on Dec 28 , 19 57 , and that death occurred at 12:31 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Olive Reid Harris		ADDRESS (Street, city or town, state) Rosewood Training School DATE SIGNED	
PHYSICIAN'S NAME (Type) OLIVE REID HARRIS		Owings Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/31/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) ARLINGTON, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.		24a. REC'D BY REGISTRAR JAN 2 1958	24b. REGISTRAR'S SIGNATURE Mary Elmer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 2 1958

RECEIVED

12875
Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delight, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-1-66</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		9b. AGE (In years last birthday) yrs. <u>91</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Records: Spring Grove Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Spring</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Goldsmith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: Spring Grove Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>D Congestive failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Cardio-vascular disease with myocardial hypertrophy and degeneration.</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>emphysema and chronic bronchitis malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 12, 1957</u> , to <u>Dec. 6, 1957</u> , that I last saw the deceased alive on <u>Dec. 6, 1957</u> , and that death occurred at <u>2:00 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Eugene Waterman</u>		DATE SIGNED <u>12-6-57</u>	
PHYSICIAN'S NAME (Type) <u>C. Eugene Waterman, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Berryman</u>		24. REC'D BY REGISTRAR DATE <u>12-9-57</u>	
ADDRESS <u>Registerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Stone</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

DEC 10 '57

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. RACE [REDACTED]	
7. OCCUPATION [REDACTED]		8. MARITAL STATUS [REDACTED]		9. EDUCATION [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. TIME OF DEATH [REDACTED]		12. PLACE OF DEATH [REDACTED]	
13. CAUSE OF DEATH [REDACTED]		14. MANNER OF DEATH [REDACTED]		15. SIGNATURE OF PHYSICIAN [REDACTED]	
16. SIGNATURE OF REGISTRAR [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF SECOND WITNESS [REDACTED]	

BUREAU V. S.

DEC 10 1957 -

RECEIVED

12885

CERTIFICATE OF DEATH

12876

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jane Middle Elizabeth Last Stocksdale				4. DATE OF DEATH Month December Day 18 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1891	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME George Stocksdale				14. MOTHER'S MAIDEN NAME Annie Yax			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-03-5614			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary heart failure - of long standing							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 3, 1957 , to 12-18, 1957 , that I last saw the deceased alive on 12-18, 1957 , and that death occurred at 6 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED							
ACTUAL SIGNATURE J. VASCONCELLOS M.D. M.D. SPRING GROVE STATE HOSPITAL							
PHYSICIAN'S NAME (Type) J. VASCONCELLOS M.D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-57		22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman & Sons ADDRESS Reisterstown Md							
24a. REC'D BY REGISTRAR DATE 12-20-57				24b. REGISTRAR'S SIGNATURE Mary B. Elise			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAILED AND STATE DEPARTMENT - BATHING 13

DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS STATE OF NEW YORK		COUNTY OF ... CITY OF ...	
NAME OF DECEASED ...		SEX ...	
DATE OF DEATH ...		PLACE OF DEATH ...	
TIME OF DEATH ...		CAUSE OF DEATH ...	
PLACE OF BIRTH ...		DATE OF BIRTH ...	
OCCUPATION ...		MARITAL STATUS ...	
EDUCATION ...		RELIGION ...	
SIGNATURE OF DECEASED ...		SIGNATURE OF WITNESS ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF CLERK ...	

BUREAU V. S.

DEC 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12886 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12877 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Sp. Pt.		c. LENGTH OF STAY IN 1b 3y01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital		d. STREET ADDRESS 1213 Mulberry Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle AARON Last STOKES		4. DATE OF DEATH Month 12 Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-7-91
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Stokes		14. MOTHER'S MAIDEN NAME Virginia A. Shelton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. 213-07-9796	
17. INFORMANT Bethlehem Steel Co. Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a. m. NONE 19 p. m.		20d. INJURY OCCURRED While NONE at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-13-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-57	
22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan Jr.		ADDRESS Balto. Md.	
24a. REC'D BY REGISTRAR DEC 16 1957		REGISTRAR'S SIGNATURE Simon L. Farber	

12248 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12887

CERTIFICATE OF DEATH

12878

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHARINE GUNTHER STRINGER</u>				4. DATE OF DEATH Month Day Year <u>Dec. 11, 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Gunther</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Schleining</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Howard C. Marchant, 222 Oakdale Rd., Baltimore 10, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, site undetermined, probably lung.</u> DUE TO (b) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arterio-sclerotic Heart Disease; cerebral thromboses</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>Dec. 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 9</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Crawford N. Kiehlbach, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>6 E. Eager St., Baltimore</u> DATE SIGNED <u>Dec. 12, 1957</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons, Co.</u> ADDRESS <u>4905 York Rd.</u>				24a. REQ'D BY REGISTRAR DATE <u>DEC 13 '57</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES M. SMITH		Male		45		1912		BALTIMORE		MD		MD		USA	
MARRIAGE		MAY 1938		MAY 1938		MAY 1938		MAY 1938		MAY 1938		MAY 1938		MAY 1938	
OCCUPATION		Carpenter		Carpenter		Carpenter		Carpenter		Carpenter		Carpenter		Carpenter	
EDUCATION		High School		High School		High School		High School		High School		High School		High School	
RELIGION		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic	
CAUSE OF DEATH		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease	
MANNER OF DEATH		Natural		Natural		Natural		Natural		Natural		Natural		Natural	
DATE OF DEATH		1957		1957		1957		1957		1957		1957		1957	
PLACE OF DEATH		Home		Home		Home		Home		Home		Home		Home	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF DEATH		USA		USA		USA		USA		USA		USA		USA	
DATE OF DEATH		1957		1957		1957		1957		1957		1957		1957	
PLACE OF DEATH		Home		Home		Home		Home		Home		Home		Home	
CITY OF DEATH		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE OF DEATH		MD		MD		MD		MD		MD		MD		MD	
COUNTRY OF DEATH		USA		USA		USA		USA		USA		USA		USA	

BUREAU V. S.

DEC 13 1957

RECEIVED

FOR STATE
HEALTH DEPT.

12888

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12879
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 2411 Rockwell Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle B. Last Sullivan		4. DATE OF DEATH Month December Day 7 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City	11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George W. Sullivan		14. MOTHER'S MAIDEN NAME Elizabeth Bankard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George S. Sullivan		Address 2411 Rockwell Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetic Mellitus (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right leg amputated several years ago gangrene			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE GEO. S. M. KIEFFER M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec 7 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10, 1957	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR DEC 11 '57		24b. REGISTRAR'S SIGNATURE Overman	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

1988
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1988

1988

1988

1988

1988

1988

1988

1988

1988

BUREAU V. S.

DEC 11 1957

RECEIVED

12729 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Highlands #27</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Baltimore Highlands #27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2919 Georgia Ave.</u>				d. STREET ADDRESS <u>2919 Georgia Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sophia</u> Middle <u>Temme</u> Last <u>Temme</u>				4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1895</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or date of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>220-30-6462</u>		17. INFORMANT Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>C.V.D.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Idel</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 2, 1955</u> to <u>Dec 7, 1957</u> that I last saw the deceased alive on <u>Dec 6, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Schmfield</u> M.D. <u>2301 Annapolis Rd</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Paul Schmfield</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>1221 Brighton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. M. Kueffer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. PLACE OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. PLACE OF DEATH</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF DECEASED</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF DECEASED</p>	
<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF DECEASED</p>	
<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF DECEASED</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF DECEASED</p>	
<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF DECEASED</p>	
<p>39. SIGNATURE OF DECEASED</p>		<p>40. SIGNATURE OF DECEASED</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF DECEASED</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF DECEASED</p>	
<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF DECEASED</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF DECEASED</p>	
<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF DECEASED</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF DECEASED</p>	
<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF DECEASED</p>	
<p>63. SIGNATURE OF DECEASED</p>		<p>64. SIGNATURE OF DECEASED</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF DECEASED</p>	
<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF DECEASED</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF DECEASED</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF DECEASED</p>	
<p>75. SIGNATURE OF DECEASED</p>		<p>76. SIGNATURE OF DECEASED</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF DECEASED</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF DECEASED</p>	
<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF DECEASED</p>	
<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF DECEASED</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF DECEASED</p>	
<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF DECEASED</p>	
<p>99. SIGNATURE OF DECEASED</p>		<p>100. SIGNATURE OF DECEASED</p>	

BUREAU V. 3

DEC 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12889 CERTIFICATE OF DEATH

12881

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>3 Vol. 4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2508 HADDANAY RD.</u>		d. STREET ADDRESS <u>18 S. CATHERINE ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Matilda</u> Middle <u>K.</u> Last <u>Thompson</u>		4. DATE OF DEATH DEC. 31, 1957	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.H.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>WILHELMIA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>JOHN H. THOMPSON, 18 S. CATHERINE ST.</u>	
17. INFORMANT Address <u>JOHN H. THOMPSON, 18 S. CATHERINE ST.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>345X</u> DUE TO <u>Pneumonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Sclerosis (far advanced)</u> DUE TO <u>2 years</u> (c) <u>904.9</u> DUE TO <u>Fractured right hip</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904.9</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1, 1957</u> , to <u>Dec. 31, 1957</u> , that I last saw the deceased alive on <u>Dec. 31, 1957</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marion Owens</u> M.D.		ADDRESS (Street, city or town, state) <u>914 D Street</u> DATE SIGNED <u>12/31/57</u>	
PHYSICIAN'S NAME (Type) <u>Baltimore 19, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 4/5-7</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR. 4101 EDMONDSON</u>		ADDRESS <u>AVE.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>IN 3 1958 M. Kelly</u>	

CERTIFICATE OF DEATH

1938

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF CORONER		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF CLERK		23. SIGNATURE OF JURY		24. SIGNATURE OF JUDGE		25. SIGNATURE OF SHERIFF	
26. SIGNATURE OF DISTRICT ATTORNEY		27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF TOWNSHIP CLERK		29. SIGNATURE OF VILLAGE CLERK		30. SIGNATURE OF POST OFFICE CLERK	
31. SIGNATURE OF SCHOOL CLERK		32. SIGNATURE OF CHURCH CLERK		33. SIGNATURE OF SYNAGOGUE CLERK		34. SIGNATURE OF MOSQUE CLERK		35. SIGNATURE OF TEMPLE CLERK	
36. SIGNATURE OF MONASTERY CLERK		37. SIGNATURE OF CONVENT CLERK		38. SIGNATURE OF NUNNERY CLERK		39. SIGNATURE OF HERMITAGE CLERK		40. SIGNATURE OF MONASTIC CLERK	
41. SIGNATURE OF ABBOT CLERK		42. SIGNATURE OF PRIOR CLERK		43. SIGNATURE OF DEACON CLERK		44. SIGNATURE OF MONK CLERK		45. SIGNATURE OF NUN CLERK	
46. SIGNATURE OF BISHOP CLERK		47. SIGNATURE OF ARCHBISHOP CLERK		48. SIGNATURE OF PRIMATE CLERK		49. SIGNATURE OF CHURCH OF ENGLAND CLERK		50. SIGNATURE OF ROMAN CATHOLIC CLERK	
51. SIGNATURE OF LUTHERAN CLERK		52. SIGNATURE OF METHODIST CLERK		53. SIGNATURE OF PRESBYTERIAN CLERK		54. SIGNATURE OF REFORMED CLERK		55. SIGNATURE OF ANGLICAN CLERK	
56. SIGNATURE OF EPISCOPAL CLERK		57. SIGNATURE OF UNITED METHODIST CLERK		58. SIGNATURE OF UNITED PRESBYTERIAN CLERK		59. SIGNATURE OF UNITED REFORMED CLERK		60. SIGNATURE OF UNITED ANGLICAN CLERK	
61. SIGNATURE OF UNITED EPISCOPAL CLERK		62. SIGNATURE OF UNITED LUTHERAN CLERK		63. SIGNATURE OF UNITED METHODIST CLERK		64. SIGNATURE OF UNITED PRESBYTERIAN CLERK		65. SIGNATURE OF UNITED REFORMED CLERK	
66. SIGNATURE OF UNITED ANGLICAN CLERK		67. SIGNATURE OF UNITED EPISCOPAL CLERK		68. SIGNATURE OF UNITED LUTHERAN CLERK		69. SIGNATURE OF UNITED METHODIST CLERK		70. SIGNATURE OF UNITED PRESBYTERIAN CLERK	
71. SIGNATURE OF UNITED REFORMED CLERK		72. SIGNATURE OF UNITED ANGLICAN CLERK		73. SIGNATURE OF UNITED EPISCOPAL CLERK		74. SIGNATURE OF UNITED LUTHERAN CLERK		75. SIGNATURE OF UNITED METHODIST CLERK	
76. SIGNATURE OF UNITED PRESBYTERIAN CLERK		77. SIGNATURE OF UNITED REFORMED CLERK		78. SIGNATURE OF UNITED ANGLICAN CLERK		79. SIGNATURE OF UNITED EPISCOPAL CLERK		80. SIGNATURE OF UNITED LUTHERAN CLERK	
81. SIGNATURE OF UNITED METHODIST CLERK		82. SIGNATURE OF UNITED PRESBYTERIAN CLERK		83. SIGNATURE OF UNITED REFORMED CLERK		84. SIGNATURE OF UNITED ANGLICAN CLERK		85. SIGNATURE OF UNITED EPISCOPAL CLERK	
86. SIGNATURE OF UNITED LUTHERAN CLERK		87. SIGNATURE OF UNITED METHODIST CLERK		88. SIGNATURE OF UNITED PRESBYTERIAN CLERK		89. SIGNATURE OF UNITED REFORMED CLERK		90. SIGNATURE OF UNITED ANGLICAN CLERK	
91. SIGNATURE OF UNITED EPISCOPAL CLERK		92. SIGNATURE OF UNITED LUTHERAN CLERK		93. SIGNATURE OF UNITED METHODIST CLERK		94. SIGNATURE OF UNITED PRESBYTERIAN CLERK		95. SIGNATURE OF UNITED REFORMED CLERK	
96. SIGNATURE OF UNITED ANGLICAN CLERK		97. SIGNATURE OF UNITED EPISCOPAL CLERK		98. SIGNATURE OF UNITED LUTHERAN CLERK		99. SIGNATURE OF UNITED METHODIST CLERK		100. SIGNATURE OF UNITED PRESBYTERIAN CLERK	

BUREAU V. 2

JAN 3 1938

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12890 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove Hospital</u>		d. STREET ADDRESS <u>116 E. Clement St.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>B.</u> Last <u>THUMAN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/02</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland Katz</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph</u>		14. MOTHER'S MAIDEN NAME <u>Mary Henneke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty Liver</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>12/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>McCully Funeral Homes - 130 E. Fort Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 57</u>	
24b. REGISTRAR'S SIGNATURE <u>William V. Lovitt, Jr.</u>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NO. 10000

DATE OF DEATH

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

DEATH NO. 10000

BUREAU V. 3

DEC 17 1957

1200

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12891 CERTIFICATE OF DEATH

Reg. Dist. No. 128831

1. PLACE OF DEATH o. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GRANITE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - GRANITE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OLD COURT RD. - GRANITE				d. STREET ADDRESS OLD COURT RD. - GRANITE			
3. NAME OF DECEASED (Type or print) First ELLEN Middle ELIZABETH Last TRAIL				4. DATE OF DEATH Month DEC Day 30 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 13, 1867	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN A. THRIFT				14. MOTHER'S MAIDEN NAME MARY F. MENIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT DAUGHTER - BEULAH GOSNELL		Address OLD COURT RD GRANITE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLISM 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DEGENERATIVE HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 11 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from JAN 10, 1957 , to DEC. 30, 1957 , that I last saw the deceased alive on DEC 29, 1957 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L. Pierpont				ADDRESS (Street, city or town, state) 8204 LIBERTY RD, BALTO MD			
NAME (Type) EDWIN L. PIERPONT				DATE SIGNED JAN 2 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-2-58	22c. NAME OF CEMETERY OR CREMATORY: Granite Pres. Cem.	22d. LOCATION (City, town, or county) (State) Granite, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers, 8728 Liberty Rd., Randallstown, Md				24a. REC'D BY REGISTRAR JAN 2 1958 24b. REGISTRAR'S SIGNATURE Dr. J. M. D. Martin			

JAN 2 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12884

12892

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LUTHER RUSSELL TYLER				4. DATE OF DEATH Month 12 Day 19 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/30/1906	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 19 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) LEXINGTON VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME SAM TYLER				14. MOTHER'S MAIDEN NAME RACHEL SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-145-473			
				17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO (b) Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH 24 days 5 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4/25/57 , 19 57 , to 12/19/57 , 19 57 , that I last saw the deceased alive on 12/19 , 19 57 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland							
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12.24.57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery, Baltimore, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.				24a. REC'D BY REGISTRAR Mary Elmer		24b. REGISTRAR'S SIGNATURE	
				DATE 12/27/57			

RECEIVED

DEC 30 1957

JEAN Y. E.

1. NAME OF DECEASED JEAN Y. E.		2. DATE OF DEATH DEC 30 1957	
3. PLACE OF DEATH [Blank]		4. CAUSE OF DEATH [Blank]	
5. SEX [Blank]		6. AGE [Blank]	
7. OCCUPATION [Blank]		8. MARITAL STATUS [Blank]	
9. RELIGION [Blank]		10. EDUCATION [Blank]	
11. BIRTH DATE [Blank]		12. BIRTH PLACE [Blank]	
13. MOTHER'S NAME [Blank]		14. FATHER'S NAME [Blank]	
15. SOCIAL SECURITY NUMBER [Blank]		16. MEDICAL HISTORY [Blank]	
17. PRESENT ILLNESS [Blank]		18. TREATMENT [Blank]	
19. PHYSICIAN'S SIGNATURE [Blank]		20. HOSPITAL SIGNATURE [Blank]	
21. DATE OF SIGNATURE [Blank]		22. PLACE OF SIGNATURE [Blank]	

CERTIFICATE OF DEATH

1957

DEC 18

Page One, Two

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12885

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 WOODLAWN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2650 W. Park Drive</u>		d. STREET ADDRESS <u>2650 W. PARK DR.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>A</u> Middle <u>Wagner</u> Last	4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1957</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-02</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>WESTMINSTER</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HARVEY RACINE</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>WM WAGNER</u> Address <u>2650 W. PARK DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Wilmer K. Gallagher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/10/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BLACK ROCK</u>
22d. LOCATION (City, town, or county) <u>BLACK ROCK PA.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. STANSBURY</u>		24a. REC'D BY REGISTRAR <u>DEC 9 1957</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

BALTO 7,

DEC 9 1957

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 9 1957

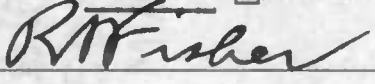

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12894 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12886

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —				d. STREET ADDRESS 1019 Mt. Holly Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MYRLE Middle BELL Last WALTZ				4. DATE OF DEATH Month December Day 8 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 24, 1896	
				9. AGE (last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edgar Jenkins				14. MOTHER'S MAIDEN NAME Elsie B. Franklin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Quentin Gunn, Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-11-1957		22c. NAME OF CEMETERY OR CREMATORY Taylorville		22d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Md.				24a. REC'D BY REGISTRAR DATE DEC 13 57		24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1951
1551
1551
1551

BUREAU V. S.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12895
CERTIFICATE OF DEATH

12887 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore 19</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>as</i> b. COUNTY <i>in</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Pt.</i>		c. LENGTH OF STAY IN 1b <i>22 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO in</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Poplar Rd</i>				d. STREET ADDRESS <i># 1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>LILLIAN</i> Middle <i>L.</i> Last <i>WATKINS</i>				4. DATE OF DEATH Month <i>DEC</i> Day <i>31</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>SEPT 11, 1911</i>	
				9. AGE (In years last birthday) <i>46</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Alabama</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>T. Bay Rochester</i>				14. MOTHER'S MAIDEN NAME <i>Julia Reid</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Marge Clark as in # 1</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno carcinoma rectum</i> <i>154X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>with generalized metastases</i> DUE TO (c) <i>Colostomy</i>						INTERVAL BETWEEN ONSET AND DEATH <i>17 yrs</i> <i>6 months</i> <i>17 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>7-1-</i> , 19 <i>51</i> , to <i>12/31</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12/30</i> , 19 <i>57</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Louis N. Tollin</i>				ADDRESS (Street, city or town, state) <i>6908 North Pt. Rd Balto. 19-md</i>			
DATE SIGNED <i>12/31/57</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		22b. DATE THEREOF <i>1-2-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FOREST HILL CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>BIRMINGHAM ALABAMA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Blight</i>				ADDRESS <i>6009 Harford Road</i>		24a. REC'D BY REGISTRAR <i>DATE 1/7/58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Dunson L. Farley</i>			

BUREAU V. S.

JAN 8 1958

RECEIVED

12896

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 511 Dunkirk Rd.				d. STREET ADDRESS 511 Dunkirk Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Thekla Vollmer Way				4. DATE OF DEATH Month Day Year 12-11 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1896	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY private schools		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Vollmer				14. MOTHER'S MAIDEN NAME Matilda Osann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-30-0801		17. INFORMANT Address M.H. Way 511 Dunkirk Rd., Balto. 12, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF UTERUS 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 16th 1957 to Dec 11th 1957 , that I last saw the deceased alive on Dec 9th 1957 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6210 YORK ROAD DATE SIGNED Dec 12 1957 ACTUAL SIGNATURE A.S. Chalfant M.D. PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT BALTIMORE, 18, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 12-13-57		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Balto. City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				24a. REC'D BY REGISTRAR DEC 13 1957		24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1957 - CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12889

CERTIFICATE OF DEATH

12889

Items 8 & 9 Film G225 12/19/57

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 5yr5mths2dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland 16252			
3. NAME OF DECEASED (Type or print) First Rosa Middle Mae Last Weeks				4. DATE OF DEATH Month December Day 1st Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1875 Jan. 12, 1895	
9. AGE (In years last birthday) 62 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William R. Anderson				14. MOTHER'S MAIDEN NAME Harriett Kohlenberg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 14 , 19 57 , to Dec. 1 , 19 57 , that I last saw the deceased alive on Dec. 1st , 19 57 , and that death occurred at 5:15 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachsler SPRING GROVE STATE HOSPITAL 12-2-57 ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12/4/57		Glenwood Cemetery Wash.		D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661 Geo Rd SE				ADDRESS HOPE		24a. REC'D BY REGISTRAR DEC 3 '57	
				24b. REGISTRAR'S SIGNATURE Overbeach			

CERTIFICATE OF DEATH

Form No. 10

PLACE OF DEATH		RESIDENT	
DATE OF DEATH		PLACE OF BIRTH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MANNER OF DEATH	
CAUSE OF DEATH		IMMEDIATE CAUSE	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
X-RAY EXAMINATIONS		PATHOLOGICAL EXAMINATIONS	
MICROSCOPIC EXAMINATIONS		BACTERIOLOGICAL EXAMINATIONS	
SEROLOGICAL EXAMINATIONS		IMMUNOLOGICAL EXAMINATIONS	
TOXICOLOGICAL EXAMINATIONS		OTHER EXAMINATIONS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. 2

DEC 4 1957

RECEIVED

14

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12890

12898

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr4mths28dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 3401.4			
f. STREET ADDRESS 2430 Brambleton Rd.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amelia Middle Caroline Last Wegner				4. DATE OF DEATH Month December Day 6 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1869	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles J. Wegner		14. MOTHER'S MAIDEN NAME Johanna Sleepack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY... IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO with mitral insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition and dehydration				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 21 , 19 57 , to Dec. 6 , 19 57 , that I last saw the deceased alive on Dec. 6 , 19 57 , and that death occurred at 4:15 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) C. Eugene Watermann, M.D. SPRING GROVE STATE HOSPITAL				DATE SIGNED 12-6-57			
ACTUAL SIGNATURE C. Eugene Watermann, M.D.				CATONSVILLE 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR DATE DEC 11 '57		24b. REGISTRAR'S SIGNATURE Paul Smith	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.



BUREAU V. 51

DEC 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12891

12899

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1 — Bacon Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>Elizabeth</u> Last <u>White</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 20 1871</u>		9. AGE (In years last birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>White Hall</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edward Harris</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Amos</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-301096</u>		17. INFORMANT <u>Anita Tittle, Redd</u>		Address <u>White Hall MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Neck of right femur</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>9049</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		
20f. (City or town) <u>—</u>		(County) <u>—</u>		(State) <u>—</u>			
21. I certify that I attended the deceased from <u>OCT. 11, 1957</u> to <u>DEC. 15, 1957</u> that I last saw the deceased alive on <u>Dec. 14, 1957</u> , and that death occurred at <u>4:17 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>—</u>				DATE SIGNED <u>12/15/57</u>			
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. <u>PARKTON, MD</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN SPENCER JACOBSON</u>				ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR DATE <u>12-19-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Forward</u>			

CERTIFICATE OF DEATH

15288

BUREAU V. 5.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

128938

Reg. Dist. No.

12900

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>Brooklandville</u>		c. CITY OR TOWN (If outside corporate limits, write <u>RURAL</u> and give nearest town) <u>near Brooklandville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>1444 Court Road</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Last <u>Whitridge</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1899</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired mfg</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>mfg</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John A. Whitridge</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Dr. Noel Whitridge</u>		Address <u>41007 1/2 Park Hill</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized and coronary arteriosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>57</u> , to <u>Dec 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 14</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter B. Buck</u> M.D. <u>185 Eager St Balto - 2</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WALTER B. BUCK</u>		<u>18 EAGER ST BALTO-2</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Dec 17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Steele & Morris</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 17 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Walter Eager</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12000

DEC 17 1957

BUREAU V. S.

DEC 17 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6, & 7, Film G223, 12/22/57, fcy

CERTIFICATE OF DEATH

12893

Reg. Dist. No.

35~

1. PLACE OF DEATH a. COUNTY <u>Baltimore.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>				c. LENGTH OF STAY IN 1b <u>82 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Middletown Rd.</u>				d. STREET ADDRESS <u>Middletown Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eli</u> Middle <u>F.</u> Last <u>Wilhelm.</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>7.</u> Year <u>1957.</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 26, 1875</u>	
9. AGE (In years and birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building.</u>		11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Peter F. Wilhelm.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Morrow.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-10-2999A</u>		17. INFORMANT Address <u>Mrs. Susan Wilhelm, Freeland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 Min.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1940</u> , to <u>Dec. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 6</u> , 19 <u>57</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D. <u>Parkton Md.</u>				ADDRESS (Street, city or town, state) <u>Parkton Md.</u>			
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>				DATE SIGNED <u>12/9/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Kortenstein, New Freedom Pa.</u>				24a. REC'D BY REGISTRAR <u>12/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>Christina G. Freeland</u>	

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The before copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12894

12902

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Lodge Forest</u>	LENGTH OF STAY (in this place) <u>25 Years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lodge Forest</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2110 Oak Road</u>		STREET ADDRESS (If rural give location) <u>2110 Oak Road</u>	
3. NAME OF DECEASED (Type or Print) <u>FREDERICKA</u> (First) <u>WILLS</u> (Middle) (Last)		4. DATE OF DEATH <u>Dec. 6, 1957</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>August 5, 1874</u>
9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Casper Gantz</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Stein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Mrs. Margaret Renner 2110 Oak Road.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Cerebrovascular Ht. Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Dec.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 5</u> , 19 <u>57</u> , and that death occurred at <u>11:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. J. Mearns</u>		ADDRESS (Street, city, town, state) <u>220 DOT. Balt. 19 Md.</u>	
DATE <u>DEC 13 1957</u>		DATE SIGNED <u>12-7-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 9, 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>	
24. REC'D BY REGISTRAR <u>Lawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

Form No. 100

NAME OF DECEASED (Print or Write)

SEX

DATE OF BIRTH

TOWN

COUNTY

AGE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

BY WHOM DECEASED

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

BUREAU V. 8

ED 13 1957

RECEIVED

RECEIVED
MAY 13 1957
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12903

CERTIFICATE OF DEATH

12895

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 255 Chatsworth Ave.		e. STREET ADDRESS 1 255 Chatsworth Ave.	
3. NAME OF DECEASED (Type or print) First Viola Middle Wilson Last Wilson		4. DATE OF DEATH Month Dec. Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1897
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Adam Keckner		14. MOTHER'S MAIDEN NAME Sarah Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Melvin W. Wilson, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoidosis (Pulmonary) 138.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19 57 to Dec. 24 , 19 57 , that I last saw the deceased alive on December 24 , 19 57 , and that death occurred at 5: A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) DATE SIGNED 48 Main Street Reisterstown, Md. 12/24/57	
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27/57	
22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. BURIAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE 12-24-57	
24b. REGISTRAR'S SIGNATURE Mary B Eline			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>NAME OF DECEASED John Doe</p>		<p>DATE OF DEATH 1957</p>	
<p>AGE 45</p>		<p>SEX Male</p>	
<p>DATE OF BIRTH 1912</p>		<p>PLACE OF BIRTH Baltimore, Md.</p>	
<p>RESIDENCE 123 Main St., Baltimore, Md.</p>		<p>CAUSE OF DEATH Heart Disease</p>	
<p>DIAGNOSIS Myocardial Infarction</p>		<p>DATE OF EXAMINATION 1957</p>	
<p>PLACE OF EXAMINATION Baltimore, Md.</p>		<p>DATE OF REPORT 1957</p>	
<p>REPORTED BY Dr. John Doe</p>		<p>REPORTED BY Dr. John Doe</p>	
<p>SIGNATURE OF REPORTER Dr. John Doe</p>		<p>SIGNATURE OF REPORTER Dr. John Doe</p>	
<p>DATE OF SIGNATURE 1957</p>		<p>DATE OF SIGNATURE 1957</p>	

BUREAU V. S.

DEC 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PNG. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12904

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WHITE HALL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Graystone Rd.</u>		e. STREET ADDRESS <u>Graystone Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Leonard Wilson Jr</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1927</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>crane operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>steel co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. L. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Delie Hoover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WWII, 45-46</u>	
17. INFORMANT <u>Mrs. John Thomas</u>		Address <u>Graystone Rd., White Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> <u>979.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>G. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-13-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u>		ADDRESS <u>622 York Rd., Towson 4, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 13 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

FOR STATE
DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

DEC 19 1957

RECEIVED

12905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md. c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery Co c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 15562 d. STREET ADDRESS 715-A GIST AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LYMAN HENRY WOLFF				4. DATE OF DEATH Month Day Year DECEMBER 19 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 20, 1902	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EDITOR		10b. KIND OF BUSINESS OR INDUSTRY GOV. PRINTING	
11. BIRTHPLACE (State or foreign country) WASHINGTON DC		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FRANK A. WOLFF		14. MOTHER'S MAIDEN NAME LILLIAN M. JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 184-05-237		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 YEAR DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from DEC 18 1957 to DEC 19 1957 , that I last saw the deceased alive on DEC 19 1957 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED							
ACTUAL SIGNATURE William Newcomer PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/23/57		22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Edw. E. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE DEC 23 1957		24b. REGISTRAR'S SIGNATURE Dorothy Howell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PRESENT MARRIAGE [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU VI

EC 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

M

00

I

2

12906

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film G223 12/18/57 GTE

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gray Manor c. LENGTH OF STAY IN 1b Gray Manor d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2609 Gray Manor Terrace		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gray Manor d. STREET ADDRESS 2609 Gray Manor Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATILDA Middle WOODARD Last 4. DATE OF DEATH Month December Day 11 Year 19 57		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 1877 9. AGE (In years last birthday) 80 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W.G.F. Filer		14. MOTHER'S MAIDEN NAME Mary E. Hass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Mrs. Celia Bauer, 2609 Gray Manor Terrace		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arterio-Sclerotic Cardio-Vas. Disease DUE TO (c) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH —	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Time	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. B. Davis EXAMINER'S NAME (Type) M. B. Davis M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR DEC 13 1957	
24b. REGISTRAR'S SIGNATURE Mrs. Edith Hawley		DATE SIGNED 12/12/57	

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12907

CERTIFICATE OF DEATH

Reg. Dist. No.

12899

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown X2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Chatsworth Ave.				d. STREET ADDRESS 24 Chatsworth Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hallie Middle Elizabeth Last Woodward				4. DATE OF DEATH Month Dec. Day 14 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1891	9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Barker				14. MOTHER'S MAIDEN NAME Frances Jane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-34-0405		17. INFORMANT Address John R. Gilbert, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC C.V. DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA							INTERVAL BETWEEN ONSET AND DEATH 48 HRS 9 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 27, 1948 , to DEC. 14, 1957 , that I last saw the deceased alive on DEC. 12, 1957 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 MAIN ST. REISTERSTOWN MD DATE SIGNED 12/15/57							
ACTUAL SIGNATURE Martin E. Strobel				M.D. 48 MAIN ST. REISTERSTOWN MD			
PHYSICIAN'S NAME (Type) MARTIN E. STROBEL							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Finksburg		22d. LOCATION (City, town, or county) (State) Finksburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 12-15-57		24b. REGISTRAR'S SIGNATURE Mary B. Eline	

DEC 17 1957

RECEIVED

12908

CERTIFICATE OF DEATH

12900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John L. WRIGHT First Middle Last				4. DATE OF DEATH Dec. 11 1957 Month Day Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-2-1900	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea-Food				10b. KIND OF BUSINESS OR INDUSTRY SELF-Employ		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John W. WRIGHT				14. MOTHER'S MAIDEN NAME Deahl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-09-6809			
17. INFORMANT ANNIE WRIGHT Address (SAME)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Atherosclerotic Cardio-vascular Disease; Coronary Artery Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1950 , to 12/11/57 , 19 57 , that I last saw the deceased alive on 12/11/57 , 19 57 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James J. White				ADDRESS (Street, city or town, state) 422 Eastern Ave, Baltimore 21, Md			
PHYSICIAN'S NAME (Type) John G. Connelly - Essex Md.				DATE SIGNED 12/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-14-57		22c. NAME OF CEMETERY OR CREMATORY oak-lawn		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly - Essex Md.				24a. REC'D BY REGISTRAR DEC 16 1957			
				24b. REGISTRAR'S SIGNATURE Edith Hurley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. S.

DEC 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 8 FilmG224 1-2-58 et
 12730
 CERTIFICATE OF DEATH

12904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>51 N. Baltimore, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4610 Linden Ave</i>		d. STREET ADDRESS <i>1 4610 Linden Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>OSCAR</i> Middle Last <i>WRIGHT</i>		4. DATE OF DEATH Month <i>December</i> Day <i>24</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1868</i> AGE (In years last birthday) <i>89</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	11. BIRTHPLACE (State or foreign country) <i>Unknown</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT Address <i>Mr Thompson - 4610 Linden - Balt, 27, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January, 1956</i> , to <i>24 Dec</i> , 1957, that I last saw the deceased alive on <i>20 Dec</i> , 1957, and that death occurred at <i>8:57 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>William Goodman</i> M.D.		1334 Sulphur Spring Rd. 24 Dec 57	
PHYSICIAN'S NAME (Type) <i>WILLIAM GOODMAN, M.D.</i>		<i>Baltimore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/27/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Linden Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Ambrase Inc 1328 Sulphur Spring Rd</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 30</i>	
		24b. REGISTRAR'S SIGNATURE <i>Wm. M. Jeffery</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. DATE OF DEATH	
13. TIME OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. PLACE OF INTERMENT		18. NAME OF INTERMENT PLACE		19. DATE OF INTERMENT		20. SIGNATURE OF INTERMENT OFFICIAL	
21. NAME OF FUNERAL HOME		22. ADDRESS OF FUNERAL HOME		23. PHONE NUMBER OF FUNERAL HOME		24. SIGNATURE OF FUNERAL HOME REPRESENTATIVE	
25. NAME OF NEXT OF KIN		26. ADDRESS OF NEXT OF KIN		27. PHONE NUMBER OF NEXT OF KIN		28. SIGNATURE OF NEXT OF KIN	
29. NAME OF PRIEST OR MINISTER		30. ADDRESS OF PRIEST OR MINISTER		31. PHONE NUMBER OF PRIEST OR MINISTER		32. SIGNATURE OF PRIEST OR MINISTER	
33. NAME OF CHURCH		34. ADDRESS OF CHURCH		35. PHONE NUMBER OF CHURCH		36. SIGNATURE OF CHURCH REPRESENTATIVE	
37. NAME OF CEMETERY		38. ADDRESS OF CEMETERY		39. PHONE NUMBER OF CEMETERY		40. SIGNATURE OF CEMETERY REPRESENTATIVE	
41. NAME OF BURIAL SOCIETY		42. ADDRESS OF BURIAL SOCIETY		43. PHONE NUMBER OF BURIAL SOCIETY		44. SIGNATURE OF BURIAL SOCIETY REPRESENTATIVE	
45. NAME OF CREMATOR		46. ADDRESS OF CREMATOR		47. PHONE NUMBER OF CREMATOR		48. SIGNATURE OF CREMATOR REPRESENTATIVE	
49. NAME OF CEMETERY		50. ADDRESS OF CEMETERY		51. PHONE NUMBER OF CEMETERY		52. SIGNATURE OF CEMETERY REPRESENTATIVE	
53. NAME OF BURIAL SOCIETY		54. ADDRESS OF BURIAL SOCIETY		55. PHONE NUMBER OF BURIAL SOCIETY		56. SIGNATURE OF BURIAL SOCIETY REPRESENTATIVE	
57. NAME OF CREMATOR		58. ADDRESS OF CREMATOR		59. PHONE NUMBER OF CREMATOR		60. SIGNATURE OF CREMATOR REPRESENTATIVE	
61. NAME OF CEMETERY		62. ADDRESS OF CEMETERY		63. PHONE NUMBER OF CEMETERY		64. SIGNATURE OF CEMETERY REPRESENTATIVE	
65. NAME OF BURIAL SOCIETY		66. ADDRESS OF BURIAL SOCIETY		67. PHONE NUMBER OF BURIAL SOCIETY		68. SIGNATURE OF BURIAL SOCIETY REPRESENTATIVE	
69. NAME OF CREMATOR		70. ADDRESS OF CREMATOR		71. PHONE NUMBER OF CREMATOR		72. SIGNATURE OF CREMATOR REPRESENTATIVE	
73. NAME OF CEMETERY		74. ADDRESS OF CEMETERY		75. PHONE NUMBER OF CEMETERY		76. SIGNATURE OF CEMETERY REPRESENTATIVE	
77. NAME OF BURIAL SOCIETY		78. ADDRESS OF BURIAL SOCIETY		79. PHONE NUMBER OF BURIAL SOCIETY		80. SIGNATURE OF BURIAL SOCIETY REPRESENTATIVE	
81. NAME OF CREMATOR		82. ADDRESS OF CREMATOR		83. PHONE NUMBER OF CREMATOR		84. SIGNATURE OF CREMATOR REPRESENTATIVE	
85. NAME OF CEMETERY		86. ADDRESS OF CEMETERY		87. PHONE NUMBER OF CEMETERY		88. SIGNATURE OF CEMETERY REPRESENTATIVE	
89. NAME OF BURIAL SOCIETY		90. ADDRESS OF BURIAL SOCIETY		91. PHONE NUMBER OF BURIAL SOCIETY		92. SIGNATURE OF BURIAL SOCIETY REPRESENTATIVE	
93. NAME OF CREMATOR		94. ADDRESS OF CREMATOR		95. PHONE NUMBER OF CREMATOR		96. SIGNATURE OF CREMATOR REPRESENTATIVE	
97. NAME OF CEMETERY		98. ADDRESS OF CEMETERY		99. PHONE NUMBER OF CEMETERY		100. SIGNATURE OF CEMETERY REPRESENTATIVE	

BUREAU V. B.

EC 20 1957

RECEIVED

12909 CERTIFICATE OF DEATH

12902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 28 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1400 Edmondson Ave.,			d. STREET ADDRESS 1400 Edmondson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Robert Middle J. Last Wright			4. DATE OF DEATH Month Dec. Day 26, Year 19 57.		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1908	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beverage Salesman		10b. KIND OF BUSINESS OR INDUSTRY Churchill, Ltd.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Walter C. Wright			14. MOTHER'S MAIDEN NAME Maybelle Anderson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Evelyn M. Wright 1400 Edmondson Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastasis 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Larynx DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks 5 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6/30 , 19 56 , to 12/26 , 19 57 , that I last saw the deceased alive on 12/26 , 19 57 , and that death occurred at 0300 p.m. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Victor F. King			ADDRESS (Street, city or town, state) Catonsville, Md.		
PHYSICIAN'S NAME (Type) VICTOR F. KING.			DATE SIGNED 12/27/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-1957	22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Strong			ADDRESS 3207 W. 16th AVE		24a. REC'D BY REGISTRAR DEC 30 '57
			24b. REGISTRAR'S SIGNATURE W. H. Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12910 CERTIFICATE OF DEATH

12903
Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 16 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2008 E. Lafayette Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH C WYN				4. DATE OF DEATH Month Day Year December 7 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/94		9. AGE (In years last birthday) yrs. 63	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Henry Wynn			
14. MOTHER'S MAIDEN NAME Sarah Horton				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI			
16. SOCIAL SECURITY NO. 220-03-4820				17. INFORMANT Address Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X CARCINOMA OF THE RECTUM WITH GENERALIZED METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 21, 19 57 to December 7, 19 57 and that death occurred at 12:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan				ADDRESS (Street, city or town, state) VAH Fort Howard, Maryland			
DATE SIGNED 12/7/57				DATE SIGNED			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS			
24a. REC'D BY REGISTRAR 12/14/57				24b. REGISTRAR'S SIGNATURE Rawson L. Farley			

Charles R. Law Mortuary, 802-04 Madison Avenue, Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1957	
AGE		SEX	
65		M	
RACE		COLOR	
W		W	
BIRTHPLACE		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
MANNER OF DEATH		CERTIFICATE NO.	
NATURAL		12345	
SIGNATURE OF REGISTRAR		DATE	
J. H. HARRIS		JAN 16 1957	

BUREAU V. 3

DEC 16 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

129048

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE RURAL BALTIMORE	
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last YAKEL		d. STREET ADDRESS 1733 FORREST AV	
5. SEX MALE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct 24, 1907		9. AGE (In years last birthday) 50 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Lumber	
11. BIRTHPLACE (State or foreign country) Carroll Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Yakel		14. MOTHER'S MAIDEN NAME Johanna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-7472	
17. INFORMANT John Wm Byron 1733 Forrest Av (stepson)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) Acut occlusion of coronary artery (c) few hours DUE TO 420.1 cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH immed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 12-20-57	
EXAMINER'S NAME (Type) John C Hyle MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/57	
22c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24. REC'D BY REGISTRAR DEC 24 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE A. M. Brown	

DEC 24 1957

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12912 CERTIFICATE OF DEATH

12905

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 41 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Baltimore (17) d. STREET ADDRESS 2538 Sycamore Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Frank Middle P Last YARBOROUGH			4. DATE OF DEATH Month December Day 22 Year 19 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1923	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Luther Yarborough			14. MOTHER'S MAIDEN NAME Malinda Marrian		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-12-6857		17. INFORMANT Clin. Rec. Vet. Admin. Hosp., Ft. Howard, Maryland. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 11 , 19 57 , to Dec. 22 , 19 57 , and that death occurred at 2:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Ft. Howard, Md. DATE SIGNED 12/22/57 ACTUAL SIGNATURE Chien WEI Fan M.D. PHYSICIAN'S NAME (Type) Chien Wei Lan, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS Charles R. Law Mortuary, 802-04 Madison Ave., Balto., Md.			24a. REC'D BY REGISTRAR DATE Dec. 31-57		24b. REGISTRAR'S SIGNATURE Dawson L. Farber

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JAN 2 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12913

CERTIFICATE OF DEATH

Reg. Dist. No.

12906

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>29</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE W. YEAGER</u>				4. DATE OF DEATH Month Day Year <u>12/17 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED		8. DATE OF BIRTH <u>2/2/1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio engineer rtd Engineer WB & A</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>JOHN T. YEAGER</u>				14. MOTHER'S MAIDEN NAME <u>ELLA CARROLL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obliterative pericarditis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarctive myocardial fibrosis</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 121, 1928</u> , to <u>Dec 17, 1957</u> , that I last saw the deceased alive on <u>Dec 17, 1957</u> , and that death occurred at <u>5:15</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D. <u>SPRING GROVE STATE HOSPITAL</u> <u>12/17/57</u> PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u> <u>Catonville 28, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Com.</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Son North + Penn. Ave. 17</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 18 57</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Tucker</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 19 1957

BUREAU V. 1

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. DATE OF DEATH: [illegible]
7. PLACE OF DEATH: [illegible]
8. CAUSE OF DEATH: [illegible]
9. MANNER OF DEATH: [illegible]
10. SIGNATURE OF REGISTRAR: [illegible]
11. SIGNATURE OF DECEASED: [illegible]
12. SIGNATURE OF WITNESSES: [illegible]
13. SIGNATURE OF PHYSICIAN: [illegible]
14. SIGNATURE OF CLERGYMAN: [illegible]
15. SIGNATURE OF OTHER: [illegible]

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF VITAL RECORDS, STATE OF NEW YORK, AND IN THE OFFICE OF THE CLERK OF THE SUPREME COURT, COUNTY OF [illegible], AND IN THE OFFICE OF THE CLERK OF THE COUNTY COURT, COUNTY OF [illegible].